DOCTORAL PORTFOLIO

IN

COUNSELLING PSYCHOLOGY

How do Psychological Therapists develop their working Knowledge of Dissociative features: An Interpretative Phenomenological Analysis

by

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Thesis submitted in partial fulfilment of the requirements of the University of Wolverhampton for the post-graduate degree of:

Practitioner Doctorate in Counselling Psychology

Award: PsychD

The following research has been conducted in line with the guidelines presented for the module: Doctoral Portfolio, PS5018.

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Declaration

The research dossier or any part thereof has not previously been in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). I further confirm that the intellectual content of the work is the result of my own efforts and no other person, beyond the role expected of my research supervisors, Dr Niall Galbraith and Dr Abigail Taiwo.

Signed.....

Date.....

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Acknowledgements

A well-known African adage “It takes a village to raise a child” is one I will draw on in expressing gratitude to the many people who have supported me throughout the journey towards completing the doctoral study in Counselling Psychology.

My first thanks go to my Director of Study - Dr Niall Galbraith and second supervisor, Dr Abigail Taiwo. I really could not have completed this research without your continued support and guidance. The personal development module facilitators Peter Creagh, Dr Robin Gutteridge and Yasmin Malik all provided space in different ways to make me go on a journey into my core self and for this, I am grateful. To Ian, Phil and Louise, thanks for helping with the recordings.

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To my dear friends and family, thanks for your belief and encouragement. Thanks to mum, Mofoluwake for your prayers and Grandma Carol, who took time to read parts of my work. Thanks, Taiwo and Bunmi for always “pushing” me to the Library! Thanks to Kehinde for always being a good host. Thanks to my children Imi, Ese, Omo, Oseta and Iyi for constantly reminding me to get on with it and to my beloved husband, Isi, for his constantly willing me on. Iremi, our little princess also deserves a mention for being an inspiration to complete the course.

Finally, I would like to thank the participants who took part in the empirical study for their time, energy and their contributions to expanding my knowledge of dissociation.

DEDICATION

I dedicate this doctoral portfolio to the memory of my father. It was his desire for me to attain excellence in my chosen career path. It's been over ten years now since his transition and not a day goes by without me having him on my mind. Dad, you always asked "when are you starting your doctorate?" I did it, Dad!

Word Count Summary

Section	Word Count
Preface	**1,958**
Academic Dossier	
Psychodynamic Essay	**3,339**
Couples Essay	**3,000**
Therapeutic Development Dossier	
Professional Issues Essay	**4,143**
Supervised Practice Portfolio	**3,300**
Research Dossier	
Introduction	**1,550**
Critical Literature Review	**8,500**
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• Abstract	**321**
• Background and Introduction	**1,294**
• Research Design	**1,580**
• Findings, analysis and Discussion	**14,300**
• Conclusion	**283**
Critical Analysis	**2,380**
TOTAL	**49,138**

All work throughout this portfolio has been appropriately anonymised and all identifiable information removed so no participant can be identified.

Preface: An Introduction to the Doctoral Portfolio

This portfolio documents a selection of work completed for the Practitioner Doctorate in Counselling Psychology course at the University of Wolverhampton. The documented work consists of a range of work that demonstrates my transition from first year trainee who came on the course with a unimodal view of therapy, having trained in Cognitive Behavioural Therapy to becoming integrative, utilising a range of therapy approaches to meet the needs of individual clients

In line with the guideline of the portfolio is divided into three main sections:

- An Academic Dossier,
- A Therapeutic Dossier and
- A Research Dossier.

Ethical Considerations

I have been guided by the ethical guidelines of the British Psychological Society (BPS), the Division of Counselling Psychology (DCoP) and of HCPC's Standards of conduct, performance and ethics for registrants in every process of writing and compiling this portfolio.

With respect to the academic dossier, I obtained signed, informed consent from clients with regard to recording of sessions and using aspects of the therapeutic processes to illustrate points in essays. Issues of confidentiality and anonymity have been respected in every section of

this portfolio. With regard to the research dossier, the ethical guideline for counselling psychologists state that researchers need to maintain congruence between model of research and the values of counselling psychology. Due regard was given to ethical considerations in every stage of the research process. Research proposal and ethical proposals were submitted and an letter of approval from the Research Ethics committee was received before any interview was conducted.

Confidentiality has been maintained throughout this portfolio. In order to protect clients, research participants, and the people they refer to (e.g., family members), the names have been replaced with pseudonyms. All other identifiable information has been removed from this portfolio so that identities of individuals could not be inferred from this document.

My Personal Values:

Each section of this portfolio shows my personal core values of respect and unconditional positive regard to all beings – clients, peers, tutors, supervisors participants in research study. The personal development aspect of the counselling psychology training has contributed to my self-awareness and growth in this area, enabling me to have developing respect for myself and others. This respect has influenced my development as a pluralistic and integrative practitioner.

The Academic Dossier

My aim to develop as a pluralistic and integrative counselling Psychologist has influenced the essays I have chosen for this portfolio. The Academic Dossier contains two essays completed in year two and three of the Doctoral programme.

The first essay included in this Dossier was completed for the Psychodynamic module. There were two options for this essay. The first was to draw examples from our practice to illustrate how we have given due consideration to psychodynamic processes in our therapeutic intervention. The second which was the one that I chose was to compare and the psychodynamic, cognitive-behavioural and humanistic approaches in counselling psychology in relation to the concept of emotions, with illustrations from our clinical work.

The rational for choosing the second option was to enable me to develop a critical application of the three grand theories of Counselling Psychology. For me, it was not enough to have been trained in all three, I needed to consolidate this learning by critically applying the three to my practice. This essay gave me the opportunity to articulate my learning process in an essay.

In the essay, I drew from the work I did with a 17-year-old male to explore how variants of the three grand theories (object relations, acceptance and commitment therapy and gestalt therapy) work with depression and dreams.

The essay suggests that there are implications for counselling psychology interventions which include the importance of having a supervisor who is oriented to pluralistic approaches to enable the development as a pluralistic and integrative counselling psychologist. There is also training implications, for example, it is not enough to teach the three grand theories, for trainees to develop confidence in knowing when to use particular approaches, core integrative and pluralistic modules would need to be incorporated into training programmes (Cooper & McLeod, 2007). The essay concludes that counselling psychologist as scientist-practitioners and reflective practitioners need to look beyond prescribed models of therapy to developing a critical application of what works with clients including systemic and ecological approaches. The essay includes appendices which show case formulations from the three perspectives and poems highlighting the focus of each approach.

The second essay was completed for the Working with Couples and Families module. The essay options were to either (a) compare and contrast the similarities and differences between couples therapy and

individual therapy or: (b) compare and contrast two different theoretical approaches to couples therapy. I chose the first option. The rationale for this was that I felt as a counselling Psychology trainee, the research that goes towards preparing to write the essay would enable me develop a critical appreciation of the salient similarities and differences between working with individual and couples or families in therapy sessions. Furthermore, the wider literature indicates that similar theoretical approaches are used in individual and couple work. As I had already done a comparative essay on theoretical perspectives for the psychodynamic module, this option gives me opportunity to do another comparative essay with a different focus.

I used two vignettes, both based on composite illustrations from clients I had worked with, to illustrate the differences and similarities. I started the essay by pointing out that the theoretical models for working with individual and dyads and other multiple components of relationships all appear to have underpinnings in the three grand theories. Other models have subsequently been developed to works with couples and families. I compared the tasks of establishing rapports and therapeutic goals in work with individual and how this can be different in work with couples and families. I explore the challenges of ethical considerations, especially on the issue of confidentiality. In the essay I observed that working with couples and families provide ecological validity in that the counselling psychologist will not only be going by what is reported by the individual but

will have the opportunity to observe couple and family dynamics in the sessions, thus providing useful insight. I concluded by reflecting that the professional role of counselling psychologists would benefit from expanding beyond working with individuals to working with couples, families and communities. I noted that the professional journal for counselling psychologists in the UK had no article on couple or family work in the three year period between 2012 and 2015.

The Therapeutic Dossier

The Therapeutic Development Dossier contains two documents. The first is a *Professional Issues* essay which reflects on all elements of the three year training, documenting both my personal and professional development throughout the course. The second is a Supervised Practice Work Portfolio which explores my three years on placement as a trainee Counselling Psychologist.

The professional issues essay offer a personal account ot the journey I have taken towards becoming a counselling psychologist. I have included personal stories which I would have otherwise regarded as private. This is as a testament to my personal values on the common humanity of all human beings. We all are a combination of nature and nurture. The journey to be a counselling psychologist has not been merely about having a profession – I have had a wide ranging professional career prior to

retraining as a counselling psychologist – It is an evolution in my consciousness of my life's purpose. It transcends having the label of psychologist. It provides an opportunity for me to learn and grow to be all I can be with the children and families I work with. There lies the whole essence of why I have invested in training as a counselling psychologist. I have developed as an individual most especially through engaging in the personal development aspects of the course and accessing my own individual therapy. My professional journey has also been enhanced through the experiences I had in the various clinical placements, many pleasant, some not so pleasant, all affording me opportunity for reflection and growth.

The supervised practice placement portfolio offers a showcase of what I have learnt on each placement. It starts with an introduction which offers an insight to my personal professional ethos and goals. It articulates my commitment to a pluralistic and integrative approach to working with individuals, families and communities. For me, the role of a counselling psychologist goes beyond the therapy room. I would like to incorporate a public health perspective to my role.

My clinical placements were across three Child & Adolescent Mental Health settings and a private practice. Each of the placements offered me distinct opportunities for development. I found that no two CAMHS

settings were alike. The ethos of each CAMHS setting I was placed in, was informed by the demorgraphy of the population and local needs.

In the private practice, I observed the processes of not only offering therapy but engaging in the business side of therapy – marketing, diversifying to other aspects of applied psychology including holding training programmes and workshops, developing curriculum for training, contracting with clients for fees and record keeping.

I had four clinical supervisors all through my training. The supervisors have mainly been external to the placements, as my placements were mainly through paid employment.Whilst I had workplace supervisors, I also had supervisors who provide directions and guidance towards meeting the requirements of the course. The supervisors have all contributed uniquely to my career development. I borrow from the African adage “It takes a village to raise a child” to illustrate the uniqueness of each supervisory experience.

The Research Dossier

The Research Dossier contains a critical literature review, a methodology chapter, a qualitative research report and a critical appraisal of the research process. I have used the agency afforded by the course

programme for students to set out their research the way they like. I have therefore written each of the sections on literature review, methodology and empirical research as journal articles.

The topic I chose to research on, dissociation is a very complex topic and there are diverse models of understanding it. A systematic narrative of the literature is in Chapter 2 of the research dossier. One of the findings is that whilst there are myriads of models and approaches to working with dissociation, some complimentary, others contradictory, there is no articulation of the voice of psychological therapists on how they came to have working knowledge of the dissociative process. I considered it important, more so because I considered it important for psychological therapists to consider the influences on their development as experts in working with dissociation.

In writing the third chapter, I also found that the world of phenomenological research is not linear but comprises of a myriad of approaches which are not always complimentary. Chapter 3 will explore how I came to adopt Interpretative Phenomenological Analysis (IPA) as a methodology of choice.

The empirical study is in Chapter 4. It offers a brief background and review of relevant literature, followed by a statement of the research question and design. There were four superordinate themes, each with four subordinate themes. The discussion section analysed the findings in relation to the wider literature and concludes that the study offers a contribution to the development of psychosocial intervention with dissociative client population by articulating the voice of psychological therapists on how they developed their working knowledge of the process

A fifth chapter offer a critical review of the process and journey I experienced In working on the research study and what I have learnt along the way. The doctoral portfolio ends with appendices.

As a supplement to the doctoral portfolio, there is a confidential attachment, which contains a client study, a process report, raw data from the research project i.e. transcripts, annual progress reviews of the research process and feedback sheets for all work contained in the Portfolio and Confidential Attachment. In line with the confidentiality rights of clients and participants who have volunteered to be a part of this work, all potentially identifying information has been altered to ensure anonymity.

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ACADEMIC DOSSIER

Psychodynamic Essay

Compare the psychodynamic, cognitive-behavioural and humanistic approaches in counselling psychology in relation to the concept of emotions illustrated by examples from your clinical work

Module Leader: Dr James Porter

Associated Staff: Dr. Neil Morris, Dr. Victoria Galbraith, Garrett Kennedy

A Comparative Analysis of the Application of Object Relations, Gestalt Therapy and Acceptance and Commitment Therapy (ACT) to the treatment of an Adolescent with Depressive symptoms

Introduction

The current essay will offer a comparison of three approaches to counselling psychology as it relates to depression. The three approaches are psychodynamic, cognitive-behavioural and humanistic approaches. The importance of understanding the similarities and differences between these approaches to a counselling psychology trainee cannot be overemphasised. Firstly, they are widely acknowledged as the three grand theories of counselling and psychotherapy (McLeod, 2003; O'Brien, 2010; Strawbridge & Woolfe, 2010). Secondly, the professional discipline of counselling psychology requires practitioners to develop an integrative approach to clinical work. Thus, the British Psychological Society (BPS) requires that all counselling psychologists are trained in at least two therapeutic models that they can integrate in their clinical practice (BPS, 2012; Ward, Hogan and Menns, 2011). Thirdly, as reflective, reflexive, as well as scientists-practitioners, counselling psychologists need to be aware of what works in clinical practice and apply these to their practices.

The task of comparing the approaches is complex, as there are a plethora of approaches within each of them. For example, within the psychodynamic approaches, there are, amongst others, freudian, the different schools of

object relations and jungian analytic psychotherapy (Jacobs, 2012). Within the cognitive-behavioural school, there exist three waves of approaches. These are behavioural, with its underpinning bases of classical and operant conditioning (Skinner, 1963), the second wave is exemplified by Ellis's rational emotive behavioural therapy (Ellis & Dryden, 1997) and Beck's cognitive therapy (1976) and third wave mindfulness-based approaches, for example, acceptance and commitment therapy (ACT) (Hayes, Strosahl & Wilson, 2011). Within the humanistic paradigm, there is the person-centred approach (Rogers, 1951), Gestalt therapy (Perls, Hefferline & Goodman, 1951), transactional analysis (Berne, 1961) and more. This essay will therefore focus on one approach from each of the grand theories. These are object relations, gestalt and ACT (see appendix 1 for a comparison table of these three approaches).

The essay will conclude that for effective counselling psychology practice, a systematic integrative use of the different approaches would yield better outcomes for clients. Throughout this essay, the pronoun 'he' would be used to described the client and 'she would be used for the therapist/trainee.

The case

CW is a 17 year old male of white UK origin (see appendix 2 for details of his history and background). He was referred to CAMHS because of his mood swings and self-harming behaviour.

Comparative Overview of Object relations, Gestalt and ACT

Object relations theory is a developmental theory that emphasises the importance of interpersonal relations, most crucially, between an infant and his mother. The way the infant experiences the mother lays a foundation for how he experiences subsequent relationships. Cashdan (1998) defines object relations as human relations, i.e. the relations the infant has with itself and others (see appendix 3 for how this is formulated in therapy). There are many schools of object relations, with the prominent ones including, Klein, Fairburn, Winnicott and Bion (Cashdan, 1998).

In object relations therapy, the individual's motivation is seen as primarily the need for attachment. Solomon (1995) provides a useful exploration of salient features of Kleinian object relations. These include the infant's psychic relationship of phantasies with its first object (the mother's breast) which sets the experience of its relationship with other objects into adulthood. By age three months, the infant develops the paranoid-Schizoid position, in which he splits the ego and self into good or bad, based on its perception of the breast. This helps the infant organise chaotic experiences. Healthy splitting leads to integration and unhealthy splitting lends to fragmentation. By age 6 months, the infant develops the depressive positon during which the infant becomes aware that what it considers as part object is really whole and may develop anxiety based on how he experiences the whole object. The infant builds up defence

mechanisms with which he protects himself from painful experiences. The part object the infant introjects determines whether he grows up with self-acceptance and regulation. Projective identification is used to define how the client projects his phantasies (internal world) to the therapist or others.

Gestalt (whole) therapy is an existential, phenomenological therapy approach which is led by the lived experience of the client (Gilles, 2013; Perls, et al, 1951). The approach sees the individual as a whole and works with the whole of the individual in therapy sessions. It is an offshoot of psychoanalytic psychotherapy and has evolved, distancing itself from psychoanalysis, whilst embracing and adapting some aspects of object relations. Like object relations, Gestalt therapy is a relational therapy. Where it differs is in its focus on here and now experiences rather than how the past informs the present. Whilst not discountenancing the effect of the past on current experiences, it does not dwell on the past but focusses on what the individual is experiencing in the moment. In gestalt therapy, a person exists by differentiating self from other and by connecting self and other (Gilles, 2013).

The boundary between self and other needs to be flexible to allow for cross communication and it also needs to be firm to allow the individual to act autonomously. The absence of these two in the individual's relationship with the world around him leads to emotional suffering. (see appendix 4 for diagram of figure ground processes in Gestalt therapy).

ACT is based on the theory of evolution and is distinct from both object relations and Gestalt Therapy in that it sees human experiences as having evolved as from adaptive functioning in the evolution of human beings (Harris, 2008; Hayes et al, 2011). The approach is mindfulness based and value driven. It is experiential and several of its texts emphasises the significance of doing rather than talking in the process of therapy. The experiential exercise in therapy session is therefore the therapy.

ACT is similar to Gestalt therapy in its use of experiential exercises and focus on here and now experiences. ACT does not aim to reduce symptoms rather its aim is to enable clients to accept their private experiences (thoughts, sensations, memories, emotions and urges) as normal experiences. ACT challenges the usually held notion about happiness being the default human emotion. It contends that it is the struggle to suppress unwanted affect that causes suffering. Human suffering is normalised. If the individual has mindful awareness of pleasant and unpleasant experiences and allows them to come and go as they please, without rigid attachment to either, the suffering will ease (see appendix 5 for Hexaflex which is the ACT case formulation model).

In the work with CW, the common aspects of the three therapy approaches came to fore in that, the work aimed to enable him to embrace disowned parts of himself (object relations and gestalt) and make room for unwanted private experiences (ACT).

Orientation to Depression

According to the Diagnostic Statistical Manual (DSM-5 (2013) in order to be diagnosed as having depression, five or more symptoms present during a 2 week period (see appendix 6 for criteria). The object relations therapy and ACT whilst not being aligned to medical diagnoses, have traditionally been able to work with diagnoses. In contrast, Gestalt therapy has sought to move away from diagnoses, as it views diagnoses to be limited to seeing just parts and not the whole of an individual.

Object relations theory sees depression as a psychological state which the individual use to defend against traumatic memories, and painful internal experiences (Solomon, 1995). The theory presupposes that in order to live a fulfilling life, depression needs to be opened up in order to understand what memories of relationship difficulties in the past and present it is defending against.

Similarly, Gestalt therapy sees depression as unsatisfied needs. Perls et al (1951) propose that release of pent up energy unveils what is beneath the depressive presentation. In common with object relations, Gestalt approach view depression as having a meaning for the client, for example it might be suppressed anger which the client introjects towards self or projects towards others. In Gestalt therapy, this is called retroflection. Retroflection is defined as an action that was once directed towards the environment but turned back again towards oneself. Retroflection is a

creative means of adjusting to painful experiences and working to loosen it needs to be carried out sensitively as too rapid a move to remove it might unsettle the client and lead to self-injurious behaviour.

ACT also recognises that depression comes from the experience of adverse experiences. However, it asserts that it is the need to control the unwanted private experiences that brings on depression. The function of depression is act as a buffer between the unwanted private experiences and the individual. The unworkable actions distance the individual from their true values and when contact with the true self is lost, depression is likely to set in (Hayes et al, 2003).

The three theoretical strands held together, provides a comprehensive overview of what depression may mean to CW. They all have the ability to enable him to be in touch with the part of him that is aware of his moment – by-moment experience and not push it away. In object relations and gestalt terms, CW can be said to be turning his anger inward. When he has a falling out with his girlfriend, he would go into the bathroom and slash himself. According to him, if he did not do this, he would hurt her as she "whines" him up. This "whining" up can be said to be how his past is being represented in the present. In ACT terms, he is helped to experience what the "whinning" feels like and stay with it, mindfully. As he did this, he noticed the flow of sensation that comes with it. Being able to commit to workable actions even though he is experiencing unwanted private

experiences helps to move him towards his living true to what really matter to him in life.

Object relations approach was helpful in enabling CW to see how the pattern of the relationship he has with his parents is manifesting in other relationships and in the therapy session. His relationship with carer and girlfriend he is still angry at his parents but does not feel able to express this. Similarly, when he is angry with his girlfriend, he does not know how to respond. He was powerless against the onslaught of abuse from his dad and he experiences powerlessness when his girlfriend "whines" him up.

Thus integration of the different perspective to working with depression serves to help CW begin to understand how he developed depression as a defence mechanism against the feelings of shame and powerlessness, Gestalt therapy and ACT helps to enable him begin to accept himself as he is and ACT helps to move him toward recognising what really matters to him and take action to live true to it.

The Therapeutic Relationship and processing of affect

The three approaches differ in the way they view the therapeutic relationship. The way these are expressed in the work with CW will be explored here.

In one session, CW took a long time in talking about his mother. He asked "Why did you leave me?" Why did you not protect me from Dad?" He paused, stood up and beaconed to me to hug him. I felt within me that he wanted a mother's comfort. I reflected this to him. He sobbed. CW came into another session telling me "I thought you have also given up on me". I had delayed in seeing him because the receptionist had told me he had not yet arrived.

In object relations, the therapeutic relationship is the main means of achieving therapeutic change. The approach sees transference and counter transference in the therapeutic relationship as providing insight into the client's unconscious processes. According to Bion, the therapist acts as a container, holding the client within the therapeutic space (1962, cited in Solomon, 1995; Gravell, 2010). The trainee's ability to act as a therapeutic container in the room offered CW the opportunity to feel a sense of maternal containment (Gravell, 2010).

Whilst some schools of gestalt therapy make use of transference, they differ in the utility of the concept. Phillipson (2002) asserts the importance of transference to gestalt therapy as the client and therapist are both impacted on by the other's actions in the therapy session. However, for gestalt therapy, how the client responds to what is coming from the therapist is not merely a projection of past experiences but is related to what is happening in the therapeutic relationship itself. From a gestalt

perspective, transference needs to involve awareness of what the client is responding to in the current environment and how he is experiencing this in order to understand what is being triggered in the here and now.

ACT, whilst not specifically making use of transference, highlights the essence of common humanity. The ACT therapist makes use of appropriate self-disclosure and may share experiences that are related to the client's issue. For example Harris (2007) talks about how he relates to his anxiety making room for it rather than trying to suppress it. Similarly, Ciarrochi, Hayes and Bailey (2012) share their teenage struggles in their ACT texts. These two examples show how the ACT therapist relates to the client. The client has an opportunity to see how the therapist works through difficulties in an ACT consistent way and also sees self-compassion in action in how the therapist is self-compassionate when they have not been value consistent.

The trainee created a safe place for the CW during sessions. In the two examples given above, she was aware that CW was projecting unto her his need to feel contained and fear of being abandoned once again. It was important to utilise empathic reflection to him. Rather than taking the object relations approach and alluding to how he must have felt with his parents, the trainee chose to stay in the here and now experience of fear of abandonment. There was no interpretation. On reflection, perhaps there was a fear on the part of the trainee that making attempt at interpretation

might destabilise CW. This might have been a confidence issue about using object relations ideas.

Working with Dreams

CW had nightmares on a frequent basis all through our sessions. Here are two of them

1. About 16 weeks into our session, CW came into the session all tearful. He has not been sleeping well. The night previous to the session he had dreamt that he was walking home from college when he noticed a car was following him. He stopped and saw that it was his father, glaring menacingly at him. He picked up his pace and ran home as fast as he could but his dad ran after him. He managed to get home, open the door and tell his carer to bolt the door but just before she could, his father forced the door open and charged at him, punching him to the ground.
2.
3. CW had recurring dreams of finding himself in an empty house and being trapped by boys who wanted to kill him. He fought blindly and killed all of them. He was drenched in their blood.

In object relations, as with play and drawings, dreams provide a means of free association (Solomon, 1995). CW's dreams seemed to be related to the imminent release of his father from prison and his anxiety about his safety. CW's inner phantasy world was captured in these dreams, giving insight into the acute anxiety he was experiencing.

The gestalt approach to working with dreams involves bringing in to the therapy space the content of the dream so that it may be experienced in the here and now. The client becomes each of the parts in the dream. According to Phillipson (2002), each part is a projection of the client's contradictory parts and dreams represent aspects of self that are unresolved.

In ACT, the dream experiences are brought to the here and now and the client is encouraged to experience the full range of the emotions. Thus in the work with CW, having experienced the object relations depressive position he in in his first dream and the Paranoid Schizoid position of the second, he was invited to feel the emotions in the session, making room for them. CW cried in the session and trembled.

The first time, CW narrated a dream sequence, the author had little or no knowledge of how to work with dreams. She told him about this and said she would consult with her supervisor and get back to him. Use of supervision enabled her to utilise an ACT approach to working through CW's dream. It is possible that integrating this with the object relations and gestalt approach would have yielded more insight for CW.

Implication for Counselling Psychology

Clearly, each of the three approaches having their advantages and disadvantages. Hemsley (2010) stresses the need to consider the effect of

early childhood experiences in working with traumatised clients. She however noted that working with psychodynamic approaches may be constrained by time limitations. Therapists' awareness of unconscious motivation stemming from themselves or the clients is useful. It can however be contended that the mindfulness focus of ACT, helps to give insightful awareness to aspects of clients they were not aware of previously.

The importance of supervision to work on this case has been mainly from an ACT perspective. Incorporating aspects of Gestalt and object relations has been useful in providing a different dimension to the relational approach to the work. James and Martin (2013) stress the importance of a relational approach to counselling psychology. Hubble, 1999, cited in James et al, 2013) contends that the relationship between the therapist and the client is the single most important factor on the outcome of therapy. as what is known from an object relations perspective has was applied in the language of ACT bringing dreams and affect into the here and now and opening space for CW to take mindful awareness of these private experiences whilst taking committed action towards his values.

For a counselling psychology trainee who is being trained in pluralistic approach to therapy, having a supervisor that adheres to one approach can be tricky. However to deny the advantages of other approaches to fit in to supervisor expectations, might be placing the client at a disadvantage

of having the full range of what the therapist has to bring. The challenge for counselling psychology training is to prepare trainees how to present a pluralistic approach in supervision where the supervisor uses a single approach. Alternatively, perhaps, it is time for counselling psychology training providers to consider having trainees supervised by counselling psychologists or other therapists who adhere to an integrative approach.

There is also training implication on the application of systematic use of integrative approach to therapy. Ward, et al (2011) found that trainees are not necessarily confident about integrating models. As the traditional dichotomy between the approaches begin to pale, for example, psychodynamic and the humanistic approaches are increasingly having evidence-based research to support them (Harvard Medical School, 2010; Johansson, Bjorklund, Hormborg, Karlsoom & Hesser, 2013; Luyten & Blatt, 2011), the claim of CBT approaches to evidenced-based practice is gradually being eroded. Similarly with the advent of humanistic approaches to CBT in which there are little or no need to challenge cognitions, the age-old critique of CBT as being non-relational is also being eroded. Counselling Psychologists have a role to play in the advance of pluralistic approach to psychology and therapy.

Conclusion

The essay has compared the use of three approaches (object relations, gestalt therapy and ACT) to counselling psychology. The three approaches

share the common goal of aiming to enable the client to reconcile disintegrated parts of self and experience their fullest self. Whilst the author has practiced from a mainly Acceptance and Commitment therapy framework, integrating aspects of other models like object relations and gestalt therapy, appear to benefit CW and other clients she has worked with. There is also the importance of working with the client's network, thus systemic work is very important especially when working with young people who are still dependent on carers.

In conclusion, for effective counselling psychology practice, a systematic integrative use of the different approaches would yield better outcomes for clients. Furthermore, the importance of the client's ecological system and the need for counselling psychologists to work within this framework would be emphasised. Counselling Psychologists have a pivotal role to play in the systematic integration of approaches to psychotherapy. Their role as scientist-practitioners places them at a vantage point to disseminate and contribute to evidence-based practice. Likewise their role as reflective practitioners places them in a position to draw practice-based evidence based on what they have found to work in their clinical practice.

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APPENDIX 1 – Comparisons of Object Relations, Gestalt and Acceptance and Commitment therapies

	Psychodynamic (Object Relations)	Humanistic (Gestalt)	Cognitive-Behavioural (ACT)
Role of the unconscious	Unconscious	Conscious/ unconscious	conscious
The therapeutic relationship	Intervention is centred on the therapeutic relationship through Transference/ countertransference /Therapist as interpreter	Intervention is centred on the therapeutic relationship through congruence	Common Humanity/Self-disclosure/Therapist as Teacher
Philosophical underpinning	Developmental	Existential/ Phenomenological	Evolutionary/ Contextual
Focus	Effects of the past	Here and now	Here and now
Processing of Emotions	Free Association	Focusing	Mindfulness
Formulation	Malan's Triangle	Fluid through session – Figure and ground	Hexaflex/Five areas formulation
Goals of Therapy	Reduce depressive anxieties ad persecuting fears which are brought on by the harshness of internalised objects	Awareness and insight	increase psychological flexibility

APPENDIX 2 - Case Formulation for CW

Presenting Problem

CW is a 17 year old male of White UK origin. He was referred to CAMHS because of concerns about his low mood and self-harming.

Background

CW is the eldest of four siblings. His earliest memories were of his parents arguing and hitting each other. Mother left home several times When CW was 5, his mother left home and never returned. CW remembers that physical abuse from his father commenced at this time. He became responsible for his siblings and felt he needed to protect them. He saw the abuse from his father as having a protective factor for his siblings as his father was not hitting them.

CW got a respite from his father's physical abuse, when his stepmother joined the household when he was 8. He remembered being happy to have a mother figure in the home who cooked and got them ready for school. However, the pattern of the relationship between his mother and father repeated itself with his stepmother. They argued a lot and stepmother would abscond from home on several occasions. When he was 11 years old, she also left home and never returned, leaving her son, CW's half sibling behind. CW also perceived that whilst his stepmother was nice, she favoured her son over his older half-siblings.

According to CW, when stepmother left, his dad resumed his physical abuse. This abuse continued until when CW was 15. His father had kicked him down the stairs, breaking his arm. When he got to school, the arm was throbbing and school got an ambulance that took him to hospital. He had told school and hospital staff that he had fallen off his bed. He arm was put in a sling. When he arrived back home, his father asked him about the sling and he told him what had happened. Dad accused him of lying about the injury and kicked him again.

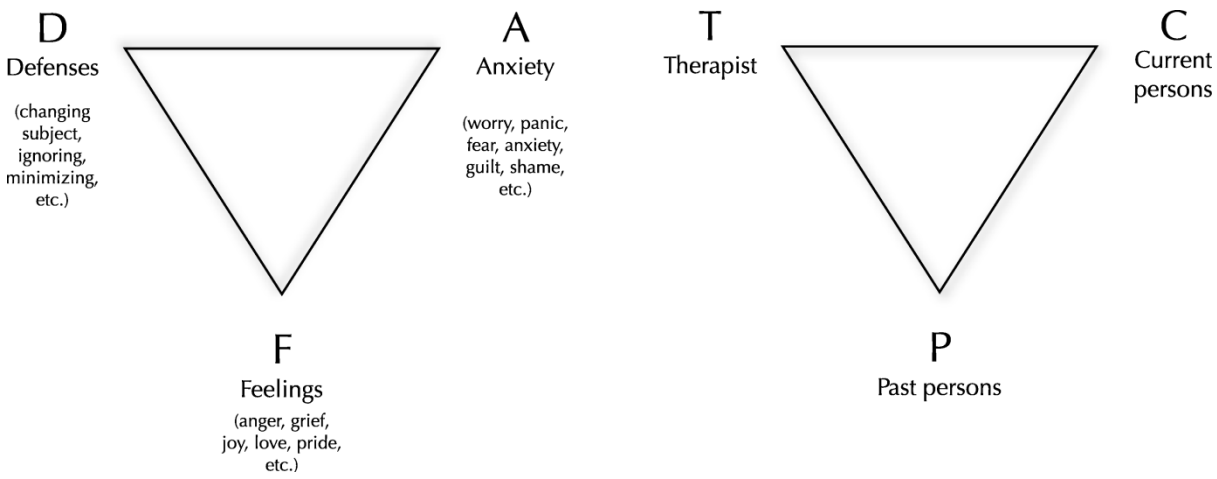
CW ran away and went first to live with his mother who rejected him again. At the time of the referral, he was living with his girlfriend and her mother.

When CW left home, his Dad started abusing his immediate younger brother. Staff at school saw the injuries and CW's younger brother revealed what had been going on at home. Dad was arrested and imprisoned. CW's three siblings were placed with paternal grandparents. Paternal grandfather is described as aloof and playing no role in caring for

the children. Paternal grandmother, whilst caring, is more invested in her son, their father. She would ask the children to call their father in prison so as to make him happy. CW reported her as having told him that she had endured worse physical abuse from her own father and her husband and she is not complaining.

CW feels guilty about what happened to his younger siblings when he left home. He felt he should have remained as this would have kept the Police and local authority away. He refused to testify against his father and blamed his brother for “shopping” him. At the same time, he fears his father and had recurring dreams of his father coming out of prison and chasing him

APPENDIX 3 - Malan's triangles of conflict and insight

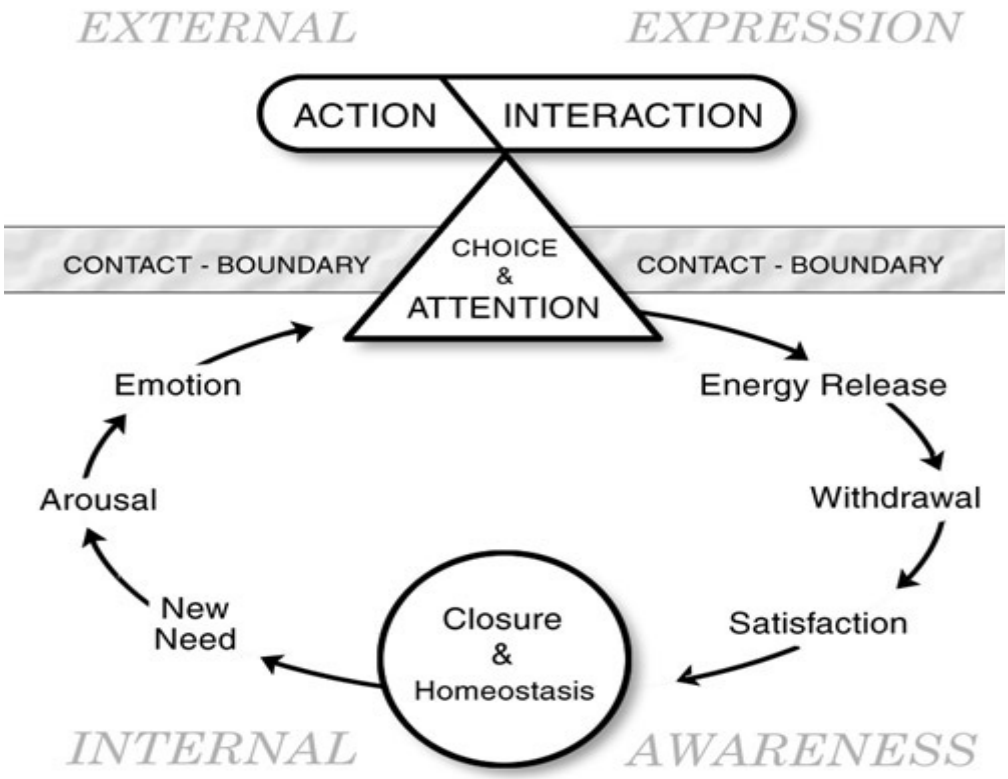


CW has a fear of the trainee not being available. He also sabotaged sessions by not attending. It appeared that he was finding it to feel contained in the sessions. After 28 sessions, CW made the decision to terminate therapy.

AT age 17, CW was left with little or no choice but to go and live with his girlfriend and her family. Whilst his girlfriend's mum exceptionally loved to him and assured him that even if his relationship with her daughter ended, he may go on living with the family, CW found it difficult to be reassured. His carer came to two sessions with him. He chose to leave the placement and move into supported lodgings.

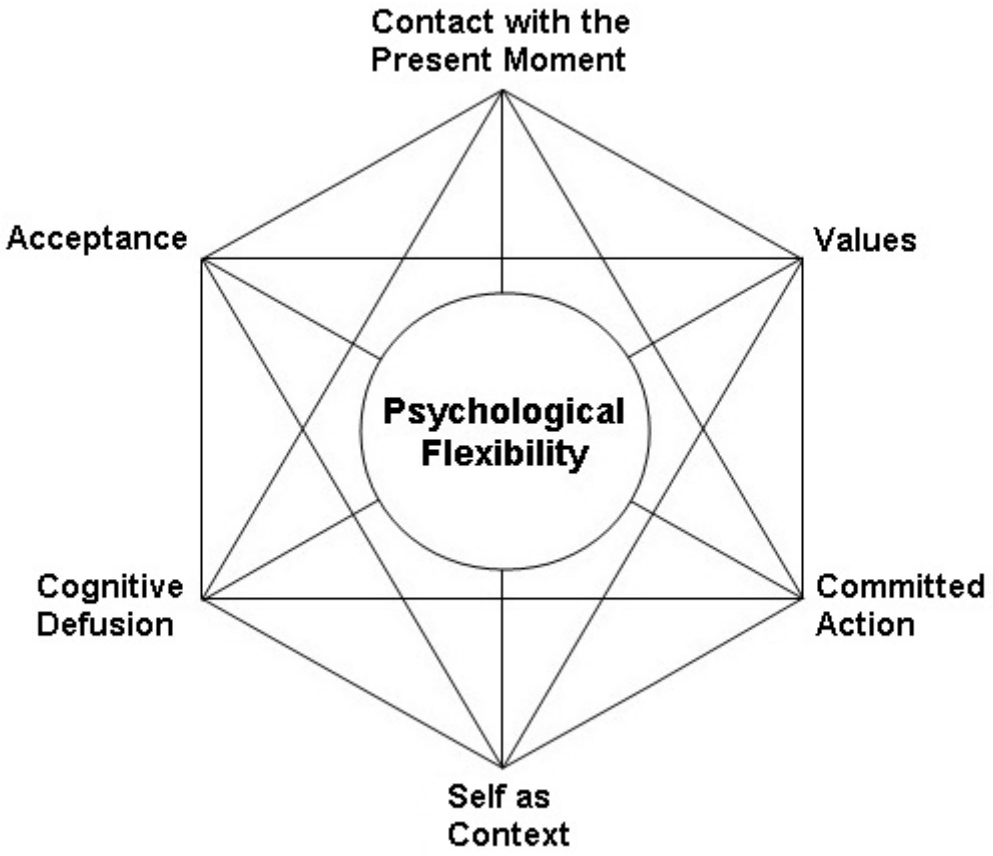
His relationship with his mother filled with memories of rejection. His available parent was physically abusive to him. CW grew up witnessing violence between his parents. Within his family, he experienced himself as the one who needs to make other people feel better. He introjected feeling of worthlessness and self-harms.

APPENDIX 4 - Gestalt Figure/Ground Processes



The figure-ground concept of gestalt therapy enabled a smoth transition from what is in CW's conscious awarenss and what is unconscious

APPENDIX 4 - ACT Formulation: Hexaflex



CW and the trainee worked together to enable him access what really matters to him and

He was fused to unwanted thoughts like:

I am worthless
My life is pointless
I don't deserve to be happy
Nobody likes/want me
I am damaged goods

Emotions and sensations he sought to avoid are:
Feelings of shame
The urge to cut himself to release pent emotions
Feeling wiehghed down
Fear
Sadness

His safety behaviours which proved unworkable are
Slashing himself
Cutting contact with people that he likes

His values are:
I want to be a loving friend
I want to have a good family relationship
I will like to be work in the helping professions
I love sports and walking

Through various experiential exercises, CW gained a mindful awareness of his private experiences in the present moment.

It is possible that his terminating therapy and moving to live on his own is where he is at at living through to his values.
He continues to see his social worker and his engaged inhis studies and friendship group.

Appendix 6 – Poems: Psychodynamic, ACT and Gestalt Therapies

Psychodynamic Poem

…He merely told
The unhappy Present to recite the past
Like a poetry lesson til sooner
Or later it faltered at the line where

Long ago the accusations had begun,
And suddenly knew by whom it had been judged,
How rich life had been and how silly,
And was life-forgiven and more humbled.

- From In memory of Sigmund Freud, W.H. Arden (1939) culled from Dryden and Mylton (1999)

ACT

The Serenity Prayer
God grant me the serenity
to accept the things I cannot change;
courage to change the things I can;
and wisdom to know the difference.

Living one day at a time;
Enjoying one moment at a time;
Accepting hardships as the pathway to peace;
Taking, as He did, this sinful world
as it is, not as I would have it;
Trusting that He will make all things right
if I surrender to His Will;
That I may be reasonably happy in this life
and supremely happy with Him
Forever in the next.
Amen.

- Reinhold Niebuhr

The Gestalt Prayer

I do my thing and you do your thing.
I am not in this world to live up to your expectations,
And you are not in this world to live up to mine.
You are you, and I am I,
and if by chance we find each other, it's beautiful.
If not, it can't be helped. - (Fritz Perls, 1969)

Couples Essay

Compare and contrast the similarities and differences between couples therapy and individual therapy

Module Leader: Dr Nick Banks

Associated Staff: Dr. Robin Guttridge and Garrett Kennedy

A comparative discourse on Couple and Individual Therapy: Implications for Counselling Psychology Practice

Introduction

Traditionally, Counselling Psychologists have focused more on working with individuals, than on working with dyads or other multiple constituents of a family system (Alilovic & Yasmine, 2010). However, emerging evidence is showing the benefits of working with family or couple systems, even where the primary reason for referral is the individual (Chambless, Miklowitz & Shoham, 2012, Chambless, 2012; Lo Tempio, 2013; Whisman, 2012). It therefore seems imperative for counselling psychologists to develop critical appreciation of the utility of working with individuals and relationships.

The current essay will offer a comparison of the two approaches, exploring the historical background to relationship and individual therapy. Drawing from two composite case vignettes of work with a family system and a couple (anonymised), it will draw on the evidence-base for using either, the ethical dilemmas that counselling psychologists would need to consider and the implication for counselling psychology practice and research. For the purpose of this essay, couple/family therapy would be referred to as relationship therapy.

Given the myriad of theoretical approaches within and across the two modalities, making a comparison between approaches cannot be done on a superficial level. It would depend on what approaches are being compared. The word limitation for this essay precludes in-depth comparative analysis. It would therefore focus on comparing the salient similarities and differences that the psychological therapist would encounter, irrespective of approaches used.

The essay will conclude that individual and relationship therapies both have their strengths and limitations. Effective counselling psychology practice needs to be resourced to have working knowledge of what is in the best interest of individual referrals. Furthermore, other innovative and creative approaches that go beyond working with individuals and family relationships, including such approaches like group and community psychology would go a long way to making applied counselling psychology more relevant to clients.

Case Vignettes

Vignette 1:

HP is a 13 year old female of white UK origin (see appendix 2a for details of her history and background). She was referred to CAMHS because of her experiencing tics and anxiety which had made her stop attending school.

Vignette 2:

Joy, aged 21 of African-Caribbean origin and Dave, aged 24 of White UK origin have been in a relationship for 5 years and have a three year old daughter. (see appendix 2b for details of the case). Joy had self-referred for individual therapy, regarding her symptoms of depression. Initial assessment and intervention indicated that couple therapy would be a useful approach in working with her presentation.

Historical Background and Comparative overview of Theoretical Orientations

Whist the emergence of individual therapy predates relationship therapy; both modalities have drawn from similar theoretical approaches. Gurman and Fraenkel (2004) offer that the evolution of relationship therapy has gone through four phases. These are atheoretical marriage counselling which span from the early 1930s to the early 1960s, secondly, psychoanalytic, thirdly, family therapy, which emerged in the early 60s and fourthly, the phase they term as *"Refinement, Extension, Diversification and Integration"* (p. 199) which evolved in the mid-1980s. One notable omission in Gurman et al's (2004) chronology is Behavioural and cognitive-behavioural and systemic approaches.

It would appear that the evolving nature of theoretical paradigms of relationship therapy closely mirrors that of individual therapy. They draw from the three grand theories of counselling psychology, namely

psychodynamic, cognitive-behavioural and humanistic approaches (McLeod, 2003; Gurman, 2008; Datillio et al, 2009; O'Brien, 2010; Strawbridge & Woolfe, 2010). For example, within the psychodynamic paradigm, object relations theory has been used in work with individuals (Cashdan, 1988; Solomon, 1995) and relationships (Schaff & Schaff, 2008). In CBT, there are several approaches developed to work with individuals. For example, Cognitive-behavioural therapy (Beck, 1995) and Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 2012). All these approaches have also ben adapted for work with relationships (Dattilio & Beck, 2009; Harris, 2009). Within the humanistic paradigm we have transactional and gestalt therapy which are used with both individual and couples (Gilles, 2013).

There are approaches which are integration of any of the three grand theories. An example is Emotionally Focused Therapy (EFT), which can be used with individuals or relationships and is an integration of humanistic, systemic and attachment theories (Johnson, 2012). In addition, there are approaches to couple therapy that have been specifically devised for use with couples and families for example systemic family therapy (Burnham, 1986; Satir, 1988). Systemic therapy is based on the premise that client issues are embedded in their social relationships. Thus, a client's issues are situated within the context of significant relationships (Stratton & Lask, 2013). What this plethora of theoretical orientations suggest is that counselling psychologists, with their

knowledge of integrative use of different theoretical orientations are well equipped to draw from these in working with individuals and transferring this knowledge to training in relationship therapy.

Evidence-Based Practice and Practice-based Evidence

The National Institute for Health and Care Excellence (NICE, 2009) has responsibility for providing guidelines for approaches that are found to provide the best evidence for working with different client issues. Most of the evidence-base for presenting client issues have been with CBT with individuals (Roth & Pilling, 2008). However, research findings are providing evidence for the efficacy of other approaches (LoTempio et al, 2013).

Relationship Therapy is increasingly having empirical evidence supporting its usefulness in working with client presentations. For example, NICE (2009) recommends couple therapy for depression as the treatment of choice for mild to moderate depression where there is a distressed couple relationship that appears to be a factor in instigating, maintaining or re-precipitating the depressive symptoms in one partner. Couple therapy for depression tends to use an integration of elements from CBT, systemic therapy, EFT and psychodynamic therapies to ensure efficacy (Hewison, 2011; Hewison, Clulow, & Drake, 2014). Systemic family and couples therapy has also been found to have efficacy for a range of client issues (Carr, 2009). For the counselling psychologist, it is imperative to go

beyond working with a favoured approach to basing interventions on what has been found to work. Furthermore, counselling psychologists as scientist-practitioners can disseminate what works in their practice for others to replicate.

Establishing Therapeutic Alliance, Relationship, and Goals

All theoretical approaches to individual therapy place importance on the role of the therapeutic alliance and collaboration ((Dunkle & Friedlander, 1996). The therapist and client decide together on what the issues to be explored are. It is generally accepted that that one significant criterion of successful outcomes in therapy is the relationship between the client and the therapist. (Cooper, 2008). The importance of developing a working therapeutic alliance is not only important for individual therapy but relationship therapy as well (Treadway, 2010).

Bordin (1979, cited in Bartle-Haring, et al, 2012) propose that successful therapeutic alliance consists of having agreement on the goals and processes between client(s) and therapist. The salient difference in individual and relationship therapy is the challenge a relationship therapist has in forging therapeutic alliance with all participants. This can be complex and challenging as the clients may have different and conflicting agendas and goals. Bartle-Haring, et al, 2012, in a quantitative study of the difference in therapeutic alliance in individual and relationship therapy, found that newly qualified therapists appear to develop better alliance with

clients in relationship therapy. They found no difference in relationship to gender of therapist.

> Establishing an alliance with HP and her family was complex in that the members of the family had competing goals. Her brother wanted to have his old sister back and for dad to stop getting angry and shouting. Dad wanted to learn strategies he could use to help HP stop having tics. HP wanted to work through her anxiety in relationships. Mum wanted HP to return to school.
>
> With Joy and Dave, Joy wanted to be able to trust that Dave truly loves her. Dave wanted Joy to be more accepting of him and his family as he was of her and her family.

Whilst there appears to be conflicting goals and agenda, it is the role of the therapist to explore with the clients the intention behind the demands family members are making on one another. Johnson (2004) suggests that it is attachment needs that are underneath conflicts. She proposed that therapists working with relationships need to explore underlying attachment injuries that are informing conflicts. By reframing conflicts in this way, families and couples can learn to understand one another's vulnerabilities and needs.

One advantage relationship therapy has over individual therapy is providing ready means of having in vivo the issues that clients are dealing with in their everyday life. Behavioural experiments can be carried out by

clients in sessions with the very people they have issues with (Dattilio, et al, 2010). For example, constructing genograms and ecopmaps (Burnham, 1986) have been found to be very effective in eliciting family history and dynamics. Similarly, Sculpting, which is an experiential technique of constructing family relationship issues has been found to help "capture and transform stalemates in couples relationships by bringing forward the gestalt of a couple's impasse and illuminating the sense of self of in the relationship" (Papp,Scheinkman & Malpas, 2013, p. 33-34)

> In the work with HP and her family, constructing a genogram helped to bring up for exploration the loss each member of the family was experiencing at the death, two years before the start of therapy, of maternal grandmother who has been a bedrock for the family. The family had not allowed themselves to talk about her. We had a session where they all discussed what she meant to them and how they missed her.
>
> Constructing a genogram with Joy and Dave also brought up the issue of terminated pregnancy and absent fathers.

However, ideas and techniques borrowed from systemic therapy have been found to work in individual therapy (Hedges, 20065). This helps move the individual lineal discourse to exploring interactions and other points of view. This can be done creatively through use of such techniques as genograms, ecomaps, circular questioning and sculpting (Hedges, 2005).

Ethical considerations

Therapists' awareness of their own values is important in both individual and couple therapy as this may affect the therapeutic relationship (Keys and Proctor, 2007). There are ethical dilemmas involved in working with a family or couple system on the one hand and an individual on the other.

Counselling psychologists in the UK work within the British Psychological Society's Principles and Guidelines, (BPS, 2005), the Division of Counselling Psychology's professional practice guideline (undated) and the Health & Care Professions Council Standards of Conduct, Performance and Ethics and Guidance on conduct and ethics Code of Conduct, Ethical for students (HCPC, 2012a, 2012b). The three guidelines offer ethical guidance on such issues as confidentiality, informed consent, acting in the best interests of clients, respecting, and upholding the rights, dignity, values and autonomy of clients. What neither of them does is give guidance on working with couples. Margolin (1982) noted this insufficiency of ethical guidelines given by the American Psychological Association (APA). More recently, Gottleib, Laser and Simpson (2008) suggest that ethical guidelines written for therapy with individuals are not easily transferable to work with relationships. Professional organisations, for example, the association for family therapy (AFT), which specialise in working with family systems have developed code of Ethics for members who work with relationships (AFT, 2011). Counselling psychologists with interest in working with couples and families might benefit from appraising themselves of this.

With the issue of confidentiality, in individual therapy, the confidentiality is between the therapist, client and sometimes the organisation the therapist works for. However, in working with relationships, the issue of confidentiality becomes more complex. Gottlieg et at (2008) suggests that therapists need to be creative when working with relationships. For example, a policy of having no secrets in therapy between the constituents of a relationship might be built into the therapeutic contract.

> In the work with HP, I saw her as my client. She was the one referred to CAMHS. Whilst some of the sessions looked at issues within the family system, I needed to ensure that those issues that she brought up in individual sessions did not sip into the family sessions. This was to maintain confidentiality. When certain issues discussed in individual therapy are required to be discussed in family sessions, I obtained HP's informed consent. Ideally, it would have been preferable for have a separate therapist for individual and systemic work.
>
> On the other hand, the work with Joy and Dave was carried out with a principle of "no secrets" were to be kept between either of them and me. Joy who had had three sessions with me before Dave joined was aware of this.

Working with structural inequalities in Therapy

The field of counselling and psychotherapy and by extension counselling psychology is increasingly drawing on adherence to anti-discriminatory and anti-oppressive practice (Lago & Smith, 2010). Effective counselling

psychology practice would require awareness of the effect of structural inequalities within the relationship system and how factors outside of the relationship, for example, culture and societal norms inform how roles are taken up within the system. Whilst the issue of diversity is notable in individual therapy, in work with relationships, it takes a magnified dimension as the issues at play are played out in the therapy room. The therapist working with an individual, works through intra-psychic and interpersonal issues affecting the individual. When working with more than one person, the therapist has the added responsibility of sensitivity to all participants 9).

> It soon became evident that HP's family are highly patriarchal. In a session, the children talked about how their dad would not let their mother drive even though she has a driver's license. Dad responded that his mother had had an accident when he was young, hence why he does not want his wife to drive. He would rather she takes taxi or he would drive her. Mum's response was that she does not want to drive anyway as she is short-sighted.
>
> In Joy and Dave's relationship, she has always looked up to him. He is the provider in the family. He does not really want her studying whilst their daughter is young and she is pregnant. This was an issue of contention within the couple relationship.

Knudson-Martin (2008) argues that the socio-cultural context of how gender roles are seen in relationships is critical to couple and family

relationships. Where stereotypical gender roles are established, there might be underlying difficult emotions, especially if one of the family system feels oppressed. In individual work, the therapist may be able to explore this with a client who is feeling oppressed. In relationship therapy, the therapist would need to be sensitive to the relationship and work in a manner that does not undermine anyone.

Where there is evidence of domestic violence, there is the ethical dilemma of making a decision on continuing with relationship therapy.

Implication for Counselling Psychology

Awareness of systemic approach to therapy and understanding of when and how to apply these is crucial for counselling psychologists. Thus even when it is not possible for a client to have their family or partner in session, it is useful to have the family network in sight through the course of therapy. The gestalt therapy approach of empty chair technique is one way of bringing the perspective of the absent others into the therapy room (Brownell, 2010). Similarly, the systemic therapy circular questioning is a useful way of eliciting how members of a system interact even when working with individuals (Fleuridas, Nelson & Rosenthal, 1986). For example, asking each member of a relationship system, what each does when a phenomenon occurs. Asking circular questions enhances therapists' neutrality, hypothesing and equal time to focus on what each member brings (Burnham, 1986; Fleuridas, 1986).

With HP and her family, a typical question is: When HP experiences tic, what does dad do? What does brother do? What does mum do? What does HP do? In the work with Joy and Dave, a typical question is when you are disagree about an issue, what does Joy do? What does Dave do? What does your daughter do?

There are training implications for counselling psychologists wanting to offer relationship counselling in addition to individual therapy. For example, the professional practice guideline of the division of counselling psychology states that practitioners need to be aware of their limitations and not offer services in which they have no training or experience in (DCoP, undated). This brings an ethical dilemma for trainee and qualified counselling psychologists who may want to work with couples and families. Modalities in which a practitioner does not have competence, should not be used with clients. However, DCoP (undated) states that experience is not only through formal training but could be through supervision, literature, workshops and any other professional development activity.

Whilst it is important for counselling psychologist to have an appreciation of when individual or relationship therapy is useful, both approaches have limitations. There are networks beyond the individual and their family system which may be impacting on a client. The ecological systems model provides a third way that takes into consideration not only the individual and her/his immediate network but also external networks (Neal,& Neal,

2013). Knowledge of the impact of the ecological systems on the individual or family systems empowers the counselling psychologist to be equipped to work at all levels and take a collaborative approach to working with client presentations at a level that is assessed to be most useful at any given time.

Conclusion

This essay has explored the similarities and differences between individual and relationship therapy. In undertaking the research for this essay, electronic editions of both the *Counselling Psychology Quarterly* and *Counselling Psychology Review* (The Professional Journal for Counselling Psychologists in the UK) from the 10 year period from 2012 to 2015 were searched for articles relating to couple or family therapy. No article on this topic was found. The influence of counselling psychology needs to extend beyond working with individuals. For this to happen, Counselling psychology will need to develop a voice for working with couples, families and the wider system – taking the locus for change beyond the individual to the environment around them.

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Appendix 1a – Case Vignette 1 – HP

Presenting Issues:
HP is a 13 year old female of white UK origin. She was referred to CAMHS because of concerns about her not attending school for over a year. At the time of the referral she had started experiencing non-epileptic seizures and tics.

Assessment and Case Formulation
HP was initially assessed by the Consultant Psychiatrist and was diagnosed with generalised anxiety disorder and tics. Her parents had thought that she was having an organic dysfunction of the brain. All tests however ruled this out.
The Psychiatrist referred the case to me for Psychological therapy (Specifically, CBT). At the initial assessment session between HP, her parents and me, it became clear that everyone in the family had some level of anxiety and there was a systemic element to HP's presentation.

Intervention Plan
In collaboration with HP and her family, the plan to begin intervention with 4 sessions of family therapy was made. This was followed by 20 sessions of individual therapy and one family session on a monthly basis. There were also 2 parent sessions and joint review with the consultant psychiatrist. The theoretical approaches used were an integration of systemic, Acceptance and commitment therapy, habit reversal therapy, Ego state and inner child work.

The Intervention
We explored what each member of the family does when tics visit. I gave each family member a paper to write down how tics affected each member of the family. This circular questioning approach showed that:
HP scratches herself and locks herself in her room
Mum stays with HP and does everything for her
Brother locks himself in his room, blames his dad and feel alienated from his sister
Dad feels frustrated and paces the house.
The session showed a tension between son and father and HP's role within the family as peace maker. It became apparent that HP's tics comes at points of tension and serves the role of keeping the family in homeostasis.

Basic behavioural work through keeping of diary identified the antecedents and consequences of episodes of tics. Through the experiential utility of the six aspects of ACT in session and at home, HP began to notice that her tics were not involuntary but was activated when she felt anxious either by family tension or phone ringing, or when she hears a loud bang. She was fused to thoughts of being worthless and unlovable because of her experience of being bullied at school.

Outcome

By the end of the intervention, HP had a more functional relationship with her tics and was beginning to go outside of the house and attending school.

Appendix 1b – Case Vignette 2 – Joy and Dwayne

Presenting Issues:
Joy, aged 21, of African-Caribbean origin and Dwayne, aged 24 of African-Caribbean origin. At the time of intervention, they were engaged. Joy had self-referred regarding her symptoms of depression. She had been diagnosed with depression and prescribed anti-depressant after the birth of her daughter, aged 2. She stopped taking the medication after she got pregnant with her second child. She had sought therapy because she was feeling very depressed and did not want to take medication.

Assessment and Case Formulation
Initial assessment and formulation showed that joy's depressive symptoms are related to feelings of inadequacy as she was trying to juggle motherhood with university course. However as the course of therapy progressed, it became apparent that there were deep-rooted tensions in her relationship with her partner. She reported that she had aborted the couple's first pregnancy at age 16. This was at the insistence of her mother who wanted her to gain education and find a job before starting a family. Dwayne had been angered by this and has continued to bring it up. Joy was also concerned that Dwayne might not have been faithful to her as she had a call from a girl who told her that she was his girlfriend. Dwayne has denied this but rather than reassuring her would get angry when she brings up the issue. Thirdly, Joy feels that Dwayne prioritises his family over her and would take sides with his brother and mother.

I discussed the possibility of couple therapy and Dwayne joined Joy at the third session. Both of them had been brought up by their mothers and have no meaningful relationship with their fathers who were absent when they were younger. They both sought to remain together and give their children stability. Dwayne felt that Joy was stifling him and making him choose between her and his family and friends. He said he allows her to be with her family even though he has issues with her mother but when he is with his family, she feels uncomfortable. Even though they were planning their wedding, both of them feel unsafe in the relationship. They however stated that they were committed to working on the relationship

Intervention Plan
In collaboration with the couple, 12 sessions of emotionally focussed couples therapy was planned.

The Intervention
The couple attended nine sessions of couples' therapy in the course of which they explored their individual attachment styles and emotional needs. They both explored how their couple dance reflects their attachment needs with Joy pursuing and Dwayne withdrawing. As the session, progressed, they began to learn how to allow themselves to be

vulnerable with each other and let each other know how they are feeling and what they needed from each other.

Outcome

By the end of the intervention, the couple had developed a deeper understanding of how their individual attachment needs impact on the role they take on in the relationship. They had developed more functional ways of communicating their needs to each other. Joy reported that her depressive symptoms had reduced and she was looking forward to the birth of her baby.

THERAPEUTIC DEVELOPMENT DOSSIER

PS5017 - Professional Issues

Reflective Essay

A Personal account of the journey towards becoming a Counselling Psychologist.

Introduction

As the period of training as a counselling psychologist gradually draws to an end, reflecting on the journey has been natural. This writing will give a summary of my journey so far towards becoming a registered counselling psychologist with the Health & Care Professions Council (HCPC) and a Chartered Psychologist with the British Psychological Society (BPS). Van Manen (1995) describes the various ways of reflecting either being retrospective (reflecting on the past), anticipatory (reflections on the future) or contemporaneous (reflections at the time of the event). Similarly, Dewey (1964) describes reflection as educational and by reflecting we get to see how we impact on and are impacted upon by situations and experiences. This reflective essay will offer an exploration of these three approaches to reflection and offer some reflection on pre-counselling psychology, current experiences and future hopes post qualification.

I am aware that this essay is likely to be in public domain and was tempted to leave some salient issues unwritten. However, in the spirit of being authentic and recognising that my journey as a counselling psychologist is not only about being available for others but also my own personal journey to opening up to parts of myself which were disowned, I

am recognising that I share a common humanity with all I come across and will offer some insight into my own particular journey.

My Background

Writing about my journey gives a unique opportunity to give a background to how I got to be where I am now. Reflecting on my background offers an insight into the origin of my core values and beliefs. I was born in London to African (Nigerian) parents. My father had come to study in the UK and my mother had joined him in the late 60s. Shortly after my first birthday, my parents separated and were divorced a few years later. I am relating this as it set on course, deep issues – of shame, of loss, of struggle to belong. I had a primary carer in my paternal grandmother. I have very fond memories of her. She showered me with love and affection as did my father, thus giving me a secure base. However for me, growing up without my mother and negotiating step-parent relationship, left me with some intrapsychic issues which prior to training as a counselling psychologist, I thought I had worked through on my own by intellectualising. In Counselling Psychology training, I found the essence of letting others hold the space for me to explore my shadows.

I will like to note that I have a growing relationship with my mother who is the living parent I have. Being in a marital relationship, accessing training in relationship therapy and offering therapy to couples have enabled me to appreciate the complexities of intimate partner relationships and how

choice of partners and decisions made within relationships are not always about others but about individuals' attachment history and intrapsychic issues.

Sedgwick (1994) describes the term wounded healer as the notion that people in the helping professionals are drawn to their professions because they themselves have had wounding experiences which has informed their career choice. On reflection, I recognise the impetus I have to support children and their families in having stable, functioning family relationships. This I can now see comes from a deep place in my psyche.

Growing up was not all difficult. There were many happy memories.

- Of me sitting with my cousins, hearing our grandmother tell us folktales.
- Of meeting my younger siblings for the first time and building an incredible sibling bond with them
- Of having a father who doted on me. Even now, I sing to myself Wemi is a good girl" because that was my dad's song for me.
- Of going into the woods with other neighbourhood children – climbing trees and looking for snails
- Of festive occasions when we would have extended family visit
- Of my dog who came into the family when I was six. Doggie taught me a lot about affection and dedication. I was distraught when he was put down.

As Kabat-Zinn (2013) says life is full of pleasant and unpleasant experiences. Suffering comes in wanting to control our emotions and thoughts rather than simply noticing that they are transient experiences. According to Brown (2010), the need to belong is a primal instinct and people try to fit in to groups they belong to, even if it means sacrificing their authentic self. The separation from the authentic self and lack of self-acceptance in turn leads to suffering. Coming on the counselling psychology course has enabled me to have a growing acceptance of all parts of me. Thus, I see myself as transforming into full embrace of who I truly am and it is from this position I seek to work with the clients I see, to embrace all that they are.

Another considerable influence on my early years' experiences was the social milieu of Nigeria. Post-colonial Nigeria, has been highly conscious of countering structural inequalities and fight against oppression. I had a strong social conscience and the many stories of famine and war drew me to wanting to give my life to helping the disadvantaged. I wanted to be a "Mother Theresa". Whilst I still seek to make a difference, I have through, training and experience grown to appreciate that working in the helping professions is more about enabling and empowering individuals and communities to recognise the barriers and constraints to their development and wellbeing. These could be on a micro or macro level (Bronfenbrenner, 2005). True transformation comes through respecting,

validating and offering the space for people to identify their needs and work with them to meet these.

My Professional Background

I grew up with parental influence to be a lawyer and I saw it as the profession for me. I took a first degree in English and by the time, I finished this, the interest in Law had waned. I had developed interest in social work. After working for a couple of years as a broadcaster in Nigeria I moved to work with a Christian children's charity before returning to the UK, having resolved to study social work. I qualified as a social worker in 1999, following placements in a statutory child protection team and a child guidance service.

Upon qualification, I secured my first position in a statutory child protection team and worked there for two years. Having experienced therapeutic work with children and their families as a student, I was keen to take up position in a Child & Adolescent Mental Health Service (CAMHS) and applied for a post as soon as I could. Within a year of moving into CAMHS, I got the opportunity to train to specialise in whatever modality of therapy I wanted. I chose to train as a cognitive-behavioural therapist. The training was not just about CBT but included training in attachment theory, motivational interviewing, and the three waves of CBT.

I benefited from the course. On a personal level, I remember sitting at a lecture and hearing the lecturer talk about Behaviour therapy. She said "You cannot change a child's behaviour. If you want to change a child's behaviour, you need to change the environment and the child will change in response". It was a eureka moment for me as I had been dealing with some difficult interpersonal relationship difficulties. That lecture changed my approach to wanting to change people I have differences with. I resolved to change myself – respecting and valuing myself more, as I value others. Whilst the learning offered insight into my own personal psychology, the course did not require me to have my own personal therapy and I never thought I needed one.

The training in CBT made me want to learn more about psychology. I felt the course made assumptions that I had underlying understanding of psychology which I did not have much of. I decided to do a conversion course in psychology which I did over three years. It was when I finished the conversion course that I thought "Wemi, you may as well train as an applied psychologist. However, there are other factors that motivated me to train as a psychologist". I valued the contributions of psychologists to the multidisciplinary CAMHS team I was working in. The impetus to train as one also came from families in my African community who I found would benefit from psychological input. For example, I visited Nigeria in 2005 for my father's funeral and was approached by an aunt to help with a cousin's son who had cerebral palsy. I was unable to offer any help and

thought if I become a psychologist I will be able to offer more help within my community.

The march towards becoming a Counselling Psychologist

This journey started in mid-2012, when I had a discussion with a colleague in the multi-disciplinary Child & Adolescent Mental Health Service (CAMHS) where I was working. She was a trainee Counselling Psychologist. I told her I was interested in training as a psychologist and she advised that I contact the Counselling Psychology team at Wolverhampton University. Up until that time I was focussing on clinical or forensic psychology. With the benefit of hindsight, I had chanced on the right course for me. Counselling psychology has opened for me not only a way of working from a humanistic paradigm but also of exploring my own intrapsychic issues.

Developing Counselling Psychology Knowledge, values and skills

With my background in social work, I had developed values and skills in person-centred approach to working with clients. Training as a counselling psychologist has honed in the humanistic underpinning of how I work with clients. I have been asked why I am bothering to train as a counselling psychologist as I already have qualifications in social work and CBT. It has been essential for me to explore the differences between the three. Here is what I have found – social work is what you do with people and

empower them to take ownership of the process and outcome. CBT (in its traditional sense) is what you do to people, although increasingly, the third wave CBT therapies work from a tradition of seeing a common humanity between the therapist and the client. For me, Counselling psychology is what you do with people, recognising the common humanity shared with client populations. I therefore see the values of social work and counselling psychology as being congruent and counselling psychology as going some steps further in exploring my own issues as I work with clients. I have grown in my appreciation of what I bring in to professional and personal relationships. When I find someone difficult, I wonder at what parts of me are coming into play. The influence on me here is undertaking the 8 week 'mindfulness based stress reduction' course, 'emotionally focussed therapy' and training in acceptance and commitment therapy (ACT).

Professionally, I see myself as an integrative counselling psychologist, working from a base of humanistic tradition and building on these perspectives from other traditions like acceptance and commitment therapy and EMDR. In my work, I start with clients from where they are. If they start with talking about cognitions, I explore that with them, then go down to feelings and body sensations. I find this flexibility enables clients to feel validated.

Personal Therapy

The course requires trainees to have at least 30 hours of personal therapy. Having never had therapy before, I started off the processes with the singular aim of meeting the course requirement. However as I continued with therapy, it became something I wanted to do for myself. Over the three years of training, I had three therapists – gestalt, focusing-oriented and psychosynthesis psychotherapists. My experience of the 3, offered me insight into my own internal processes and reflections on how clients may see me and the difficulty in opening up to an unknown other.

The process of therapy allowed me to tap into my early childhood issues, allow myself to feel the range of emotions that come with my experiences, rather than merely being logical and explaining them away. Therapy enabled me to reclaim disclaimed parts of me. I am learning to feel comfortable with praise, make space for difficult emotions, listen to that child in me that did not have her mother around and open up to having some of my attachment needs met.

Opening up in therapy sessions was not always easy. I remember one of my therapists asking me “what will you like to explore today?” I remember pondering if I really wanted to open up to this therapist. “Can he hold me?”, “Is he experienced enough?”, “He’s only young”. I made the decision to open up and benefitted greatly from the session. It made me

reflect on what might be going on in clients' minds when I ask them for their agendas and goals for sessions. I am patient with clients' ambivalence and appreciate more why Yalom (2002) asserts that having personal therapy is the most important part of psychotherapy training.

With regard to the types of therapists I went for, I have wondered why I did not go for a counselling or clinical psychologist. The answer is that I found psychologists to be expensive, especially ones with experience. In seeking therapy, I wanted someone who can offer depth work and was not looking at academic qualifications. This has made me ponder on how the general public perceive psychologists and what added value I hope to bring to my role. As a counselling psychologist I see my role as going beyond offering therapy to include offering consultation, training, supervision and leadership in applied psychology.

First year Placements – Coventry & Warwickshire Mental Health Trust and Birmingham Centre for CBT

In the first year, I had two placements, one in a CAMHS team and the other in a private practice. My First year placements were first at a CAMHS team, then in private CBT practice, where I worked with children, adolescents and adults. I also worked with couples. Throughout these placements, I had the same supervisor. This gave me a level of continuity.

Having been introduced to humanistic approaches in Year 1, I was eager to use this approach in my work and was amazed at finding that just being in the therapeutic space with a client can help shift their presentation. Of my work with JS, a 14 year old who was referred for selective mutism, I remember her begin to open up and talk, simply by me making the session about her and not hurrying her to talk. This case opened up for me the benefits of humanistic approaches and use of silence in sessions.

On my second placement, I had been working with a 14 year old who reported herself as having suicidal thoughts. About four sessions into my work with her, her mother reported that the sessions had brought back memories and emotions that she had buried. My supervisor and I discussed this in supervision and she met the young person for one session, to offer body resourcing. 'Body resourcing' is an approach to therapy where therapeutic intervention is built on and alongside enabling the clients to become aware of parts of them where they feel grounded and centred. 'Guided imagery' may also be used to visualise safe places as well as nurturing and protective figures (Korn & Leeds 2002).

I observed with awe how my supervisor worked with CB, through enabling her to “hear” her body communicate with her, to build resource for feelings of safety when she feels threatened by overwhelming emotions. I was impressed at how CB who had come in to the session looking “zoned out” became present and engaged. This was turning point in my approach to therapy. My supervisor taught me that slow is faster and to use

playfulness, empathy, curiosity and acceptance (Hughes, 2005) in every session. I found that clients respond to gentle pacing and leading rather than being led and dragged along in sessions.

Second year Placement – Shropshire and Teldord Mental Health Trust

My third placement which was my placement in my second year was in a CAMHS team. Through the course of this placement, I have developed more in-depth understanding of a range of mental health diagnoses and how to use the trans-diagnostic ACT model to work with clients presenting with these difficulties. For example, I have developed working knowledge of how to apply ACT in working with OCD, Panic disorder, Tics and Tourette syndrome, autistic spectrum disorders, depression and eating disorders. The exposure I have had to using ACT has been helpful in my personal and professional development as I was able to experience the benefits of the mindfulness based approaches to working with clinical population.

Working closer with psychiatry has given me more informed knowledge of psychotropic medications and the side effects and benefits of these. Similarly working with other multi-disciplinary colleagues has enabled me to further understand how each discipline can complement one another in multi-disciplinary intervention. I was particularly appreciative of working with the team's occupational therapist as we both shared information on

sensory approaches to working with clients. I began to use some of her resources in sessions - balls, weighing blankets and play dough amongst others. Whilst I have used some of these materials in play therapy, I did not fully appreciate their sensory value until I worked with an occupational therapist.

Third Year Placement – Dudley and Walsall Mental HealthTrust

Having had placements across three CAMHS settings, I appreciate how the demography of the population of a service dictates the needs in each area. My last placements gave me opportunity to work from a more ecological perspective. Working not only with the children and young people referred but also with their families, schools and other agencies working with them. I found that the role of a counselling psychologist is much more than limited to the therapy room. For example, working with a young person referred for school anxiety, I found that she was anxious about leaving her mother at home as she had assumed a parental role. With supervisory guidance, I worked with her and her mother to explore systemic and attachment issues and supported mum in articulating her need for a support worker and counsellor.

Multi-agency professionals may also perceive clients in different light depending on how the client presents to them. For example, in the case of a young person who appears to be highly emotionally dysregulated, working with the systems around him helped create an understanding that

his perceived manipulative behaviour serves a function and he was not wilfully being manipulative.

I found that a creative approach to counselling psychology practice allows for more scope for desired outcome for clients – working with the children and young people referred, working with their families, groupwork, having a multi-disciplinary and multi-agency approach to work and offering consultation and training to multi-agency colleagues are all part of the counselling psychology role.

Professional Development

Over the three years of training, I have gained confidence in applying an integrative approach to my work. Having started on the course, identifying with second wave CBT paradigm, I went through a period of dissociating myself from this approach based on my finding new ways of working, especially using acceptance and commitment therapy (ACT) and EMDR. As I went on in my training, I found that I do not need to disconnect from any approach. Integration is the key to offering clients a truly humanistic underpinning to therapy (Strawbridge & Woolfe, 2010). I refer to research on what has been found to work with presenting issues. For example, I found research which supports the efficacy of a combination of ACT and habit reversal therapy for tics and Tourette syndrome. I found that replicating this in my practice worked. Working with the family gave added value to the outcome. This is practice-based evidence. I hope to

contribute to the knowledge of what works in therapy by writing about successful outcome in my counselling psychology practice.

My training has equipped me with an appreciation of what counselling psychology has to contribute to the mental health wellbeing of the population. Prior to coming on the counselling psychology course, I had explored doing an MSc or doctorate in Public Health. I chose applied psychology as I believed that all other career goals can be built on it. I appreciate the role of public health awareness to different issues affecting the population and envisage that I will proactively engage in Counselling Psychology contribution to public health. To this end, I took the royal Society for Public Health (RSPH) training on Understanding behaviour change (train the trainer course). This course offers a template from which clients and their support network, multi-agency colleagues can be reached on effective ways to move away from unwanted behaviour.

I am leaving the course with an appreciation of how counselling psychology can stand equal with other disciplines like psychiatry and our sister discipline of clinical psychology. Having a firm grounding on the unique position of counselling psychology in working with the subjective lived experiences of the whole person allows for a more holistic approach to intervention. Douglas (2010) argued that counselling psychologists need to take a critical look at the diagnosis of mental health disorders. Other writers for example, Breggin (2013) and Hammersley (2009) caution

against the indiscriminate use of psychotropic medication, as they stress its potential damaging long-term effect on brain functioning. Whilst not being anti-psychiatry, I have found through supervision, and working with experienced colleagues, including psychologically-minded psychiatrists, that therapy, especially therapy that makes use of all aspects of brain functioning – cognition, emotions, body sensations and the five senses enables an awareness of and effective response to mindful awareness of what clients are reacting to.

The course has exposed me to different psychological traditions from western and eastern origin. As a soon to be qualified counselling psychologist, I am left musing about what can be learnt from an African perspective. I have perused several psychology courses in Africa and found that there is need for research on what works from an African perspective and how this can contribute to global knowledge in working with mental health. I am looking forward to contribute to the body of knowledge on what can be learnt from African psychology in working with different client presentations.

Over the course of the training, I have ventured outside of university and placement to make contributions to the Division of Counselling Psychology (DCoP). I attended my first DCoP annual conference in my first year and in the second year, I volunteered as a steward. More recently, I have become a member of the BPS's child protection working party. I

submitted a proposal for a workshop at the 2015 DCoP conference. Whilst my proposal was not accepted, I found the feedback useful and look forward using the feedback to inform future submissions.

The Black & Asian Counselling Psychology Group (BACPG) invited me to present a talk on exploring how social work and counselling psychology could work better together. This talk was an eye opener for me. And the last question I was asked "How do you see yourself now – A social worker or a counselling psychologist?" made me pause and consider the evolution of my development and transition from a social worker to a counselling psychologist. To consider this question, honestly, I see myself as both. I am wondering "do I need to shed the cloak of social work to take on the mantle of counselling psychologist?" I know a social work colleague who retrained as a counselling psychologist. He still takes on social work students and is an associate tutor on a social work programme. As I consider the next step in my career as I qualify as a counselling Psychologist, the point for reflection for me is that there is no visible conflict between the 17 years' experience I have had in child protection and therapeutic social work and being a counselling psychologist. I have added to my toolkit and value base and I do not see there is anything to jettison. I have evolved and I am still evolving.

Perhaps the most poignant moment in considering my professional identity came when recently, I visited a school open day with my youngest son. A student was talking to us about the heart and brain and I told him, "I am a

psychologist, so I am interested in this". The good thing about this statement was that it felt so natural to make that pronouncement. That was the first time, I would refer to myself as a psychologist.

Conclusion

Writing this reflective piece on my experiences on the journey towards becoming a counselling psychologist has been an emotionally gratifying exercise. I have explored influences in my background that has led to me training as a counselling psychologist. I have explored my learnings on the training programme and placements and I have explored some of the hopes I have for the future. I will conclude that I have had a life transforming experience coming on the counselling psychology course and look forward to professional experience as a counselling psychologist working cross-culturally, from a pluralistic approach, integrating psychological traditions as appropriate and contributing to research.

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SUPERVISED PRACTICE PLACEMENT PORTFOLIO

Professional Portfolio

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Counselling Psychologist-in-Training

Table of Contents

INTRODUCTION

The work portfolio offers a description of my work and training experience and how I have developed in the course of the three years of training as a counselling psychologist. In the course of these three years, I have had the opportunity to develop a range of knowledge skills and values in working with children and families, adults and professional organisations. These would be demonstrated through the detailing of the experiences I gained from the four placements I had, the voluntary and professional development activates I engaged in through the three year training as well as my CV and work samples which are included as appendices in this work portfolio.

Career Summary and Goals:

With a professional background in Social Work, spanning 16 years and subsequent training as a cognitive-behavioural therapist, I developed an interest in psychology through my experience in working with psychologists in multi-disciplinary settings. It is envisaged that the transferable knowledge, skills and values gained in the course of the three years training would be applicable to applied psychology career in diverse settings.

- Placement experience in Specialist CAMHS teams and the private sector
- Experience of integrative application of well-defined psychotherapy theories - Humanistic, CBT, ACT, EMDR
- Working with a range of clinical presentations
- Groupwork and training Experiences

Professional Philosophy/Mission Statement:

As a Counselling Psychologist, I will bring into my role an enthusiastic and committed spirit, utilising my life principles and grounding for a career with enabling and empowering others. I work from a position which recognises

and respects the individuality of each person whilst appreciating the common humanity of private and public experiences. I aim to maintain open curiosity, reflective space and empathic listening in work with individuals, families, groups and communities.

Personal Qualities

I am a highly motivated, resilient, and determined practitioner, which I hope this portfolio demonstrates. In addition to this, I work within ethical frameworks and to the scope of my knowledge and core competencies: As determined by my professional affiliation with the British Psychological Society (BPS), Health Care Professions Council (HCPC), and Division of Counselling Psychology (DCoP).

In summary, I have:

- Ability to work independently
- Able to use own initiative and think outside of the box
- Empathic and compassionate
- Resilient
- Flexible
- Well-developed verbal and written communication skills
- Analytical skills

Qualifications

- BA (Hons) English (1990)
- MA/DipSW (1999)
- MSc, Applied Social Learning & Counselling (2006)
- Professional Certificate in Management (Health & Social care (2007)
- Diploma in Psychology (Conversion for Postgraduates (2011)
- Certificate in Relationship Counselling (Conversion course for qualified Counsellors) (2013)

Professional Affiliations

- British Psychological Society (BPS) Graduate Member with GBR
- In-training member, Division of Counselling Psychology (DCoP)

- Member, Division of Occupational Psychology (DOP)
- Member, Special Group in Coaching Psychology (SGCP).
- Member, British Association of Behavioural & Cognitive Psychotherapies (BABCP)
- Member, EMDR UK & Ireland
- Registered Member, British Association of Counselling & Psychotherapy (BACP)
- Registered Social Worker (HCPC)
- Working towards HCPC accreditation as a Counselling Psychologist

SUPERVISED PRACTICE PLACEMENTS

Over the three years of my training as a Counselling Psychologist, I had four placements three of which are specialist tier 3 CAMHS teams and one of which was a Specialist CBT Private Practice.

ORGANISATIONAL CONTEXTS OF SPECILIST CAMHS SERVICES

Specialist CAMHS refers to tiers 3, 3.5 and 4 of the broader comprehensive CAMHS offering, which incorporates:

The different tiers of CAMHS services are:

- Tier 1 – universal services to enhance emotional health for all Children. These include the overall children workforce.
- Tier 2 – targeted services for vulnerable/in-need children
- Tier 3 – specialist services for children with moderate to severe mental health difficulties.
- Tier 3.5 – The 3.5 services have recently been established in response to the need to enable children and young people who require acute services to continue to be seen in their own community rather than being moved to inpatient services which may be a long distance from their home and family.
- Tier 4 – In-patient services for children and adolescents whose clinical presentation cannot be addressed in community setting.

Specialist CAMHS are provided by multidisciplinary teams consisting including psychologists, psychiatrists, nurses, primary mental health

workers, social workers, speech and language therapists, dieticians, occupational therapists, systemic, child, art psychotherapists and counsellors.

Key Relationships and Stakeholders:

- Children, young people and their families
- Multidisciplinary staff team
- Management Team
- Social Care
- Schools
- Voluntary Agencies

Clinical Governance and Quality

- Contribute to the promotion of quality improvement by working to meet waiting list target
- Adhering to NICE and other best practice guidelines
- Keeping up-to-date records of intervention in accordance with trust policy

Official Guidance:

- Every Child Matters (Department of Health 2003)
- National Service Framework for children, young people and maternity services (Department of Health 2004)
- Building and Sustaining Specialist CAMHS; consultation document (Royal College of Psychiatrists 2005)
- New Horizons – Towards a shared vision of mental health (2009)
- Children & Young Peoples in Mind: the final report of the National CAMHS Review (2008)
-

PLACEMENTS

Placement 1 - NHS CAMHS Tier 3 Service Coventry & Warwickshire Mental Health Trust

September 2012 to December 2012

Context Description

Specialist Child and Adolescent Mental Health Services (CAMHS) which provides a range of services for children and young people up to age 17, with emotional/behavioural difficulties or mental health problems, disorders and illnesses. Referral is through multi-agency professionals like GPs, schools, social workers and educational psychologists.

Services are delivered by multi-disciplinary teams with a large skill mix of staff - Child psychologists, child psychiatrists, nurses, primary mental health workers, child psychotherapists and art therapists and social workers.

Client Issues

Referrals were from tier one CAMHS services – GP's, Schools, Social Care. Client issues I worked on whilst on this placement include low mood and anxiety, selective mutism, Autistic Spectrum Disorders, attachment difficulties and family relationship difficulties.

Therapy Approaches:

- Humanistic, CBT

Supervision

Supervision on this placement was by a Clinical psychologist. In supervision, I learnt how to start work with children and young people using playful, accepting, curious and empathic (PACE). "PACE focuses on the whole child, not simply the behaviour. It helps children be more

secure with the adults and reflect upon themselves, their thoughts, feelings and behaviour, building the skills that are so necessary for maintaining a successful and satisfying life. The child discovers that they are doing the best that they can, and are not bad or lazy or selfish. Problems diminish as the need for them reduces" – Dan Hughes.

- Psychological Assessment and Case Formulation
- Evidence-based Approaches
- Report writing
- Reflective space
- Risk Assessment and management

Roles and Experiences

Formulation	Five areas formulation, use of psychometric measures including Conner's questionnaire, strengths and difficulties questionnaire (SDQ)
Therapy Modality	Humanistic, CBT
Multidisciplinary work	Participation in team meetings, Contributed to peer supervision.
Risk assessment	Screening, monitoring, assessment and management of risk

Placement 2 - Birmingham Centre for CBT (Private Practice),

January 2013 to February 2014

Context Description

The Birmingham Centre for Cognitive Behaviour Therapy provides therapy, consultancy and training services across the UK. It is based in the /South of Birmingham in a homely semi-detached building.

Members of the centre include associates from a wide range of disciplines including psychologists, Therapists, Management Consultants, Trainers and Coaches who provide a range of services on behalf of the centre. CBT Therapists are qualified psychotherapy practitioners and have a background in either Social Work, Nursing, Psychology or Counselling.
The service was founded by an accredited CBT Therapist and supervisor who is also an EMDR Consultant. She has a background in mental health nursing.

Referrals are taking directly from individuals, insurance companies, GPs, employers and legal Practitioners. The service works with children, young people, adults, couples and across a range of presentations including road traffic accidents, stress and weight issues, depression and anxiety disorders.

Client Issues

The director of the centre allocates cases based on assessed needs and therapist competence. The range of client work I worked on in this placement include couple therapy, and individual work with children, young people and adults on presentations like OCD, depression, social anxiety and couple relationship issues.

Supervision

I had the same supervisor I had in placement 1 on this placement. This ensured continuity. Supervision involved:

- Life observation of sessions
- Assessment and formulation
- Therapy process and progress
- Risk assessment and management

Roles and Experiences

Formulation	Five areas formulation, use of psychometric measures including GAD 7, PHQ 9, Dissociative Experience Scale.
Therapy Modality	Humanistic, CBT, Emotionally focused Couples Therapy
Multidisciplinary work	Contributed to peer supervision.
Multi-agency work	Liaison with GPs and CAMHS services
Risk assessment	Monitoring, assessment and management of risk
Administrative Tasks	Taking and inputting details of referrals

Placement 3

NHS CAMHS Tier 3 Service – Shropshire & Telford Community NHS Trust

September 2013 to December 2014

Context Description

The placement was within a multi-disciplinary specialist CAMHS team. According to the 2011 census, the demography of the placement locality is 98% White. 69% of the population profess to adhering to the Christian faith 23% following no religion. The make-up of the children and young people referred to the service reflects the demography of the local area.

The multidisciplinary team consist of colleagues from diverse ethnicity and professional disciplines from systemic psychotherapy, psychiatry, cognitive-behavioural therapy, occupational therapy, speech and language therapy, social work and mental health nurses. Unique to the placement is that psychology was not included in the multi-disciplinary team. Referrals for psychology input were made to the specialist psychology team.

Client Issues

Clients were referred through the single point of access by multi-agency professionals including education, GP and social workers. The majority of cases I worked on were co-worked with psychiatry when specialist CBT input was required. I developed working knowledge of how to apply ACT in working with OCD, Panic disorder, Tic and Tourette syndrome, autistic spectrum disorders, depression, Eating disorders.

Other activities on Placement:

- Involvement in multidisciplinary training
- Contributing to peer supervision.
- Member of the eating disorder pathway team

- Member of the Neurodevelopmental group

Supervision

Supervision was from an Accredited CBT Therapist. Originally trained in the Beckian Second wave CBT, she went on to specialise in the third wave acceptance and commitment therapy (ACT).

- Developed good working knowledge of ACT and this underpinned all the client work I undertook.
- Supervision was formal and informal
- Roleplays
- Therapists issues

Roles and Experiences

Formulation	Used ACT Case Formulation approach through the use of the Hexaflex.
Therapy Modality	Humanistic, ACT
Multidisciplinary work	Range of multidisciplinary work with multidisciplinary colleagues. Worked with dietician on Eating Disorder case. Worked with Occupational Therapist on ASD, ADHD and Tics cases. Contributed to peer supervision.
Multi-agency work	Contributed to Individual Education Plans, participation in transition meetings for transfer of cases to CMHT.

Risk assessment	On the Deliberate self-harm rota - assessing children and young people who have been admitted to hospital because self-harm and suicidal risks

Placement 4: NHS CAMHS Tier 3 Service – Dudley & Walsall Community NHS Trust

Tier 3 CAMHS Service January 2015 to July 2015

Context Description

The service is based in Walsall. It shares setting with other mental health services for children and young people in Walsall, including the Early Intervention in First Episode Psychosis Service and the Eating Disorders Service. It is also the Central England centre for the national Deaf Children, Young People and Family Service.

The service provides assessment and treatment of moderate to severe mental health difficulties that children and young people experience. It aims to:

- Provide specialist assessment and treatments in accordance with best practice and NICE recommendations.
- To provide appropriate information for young people and their families and for other agencies in accordance with confidentiality and consent to share protocols.
- Consultation and liaison and training for universal and targeted services including professional carers.

The CAMHS team is multi-disciplinary and consist of multidisciplinary colleagues from psychiatry, psychology, speech and language therapy, systemic psychotherapy, CBT, mental health nursing, social work and child psychotherapy.

Referrals are made directly to the service by mufti-agency professionals including GP, schools and social workers. The duty manager works

through referrals and ensures that they are allocated for choice appointments.

Client Issues

In this placement, a majority of the workload consists of using a systemic approach to work with the children and families. The range of client issues worked on includes:

- ASD
- School Refusal
- Depression and Anxiety disorders including OCD, Panic disorders, Social anxiety and PTSD

Therapy Approaches:

- ACT
- Theraplay
- Creative Therapies
- Eye Movement Desensitisation and Reprocessing (EMDR)

Supervision

Supervision on this placement has been from an Accredited Cognitive-Behavioural Therapist and Supervisor. She is also an EMDR Consultant.

The supervisory experience has focused on:

- Developing well developed knowledge and skills in working with complex clinical presentations like emerging borderline personality disorder
- Working with children and the systems around them

- Working towards EMDR and CBT accreditation.
- I was also privileged to have case management supervision from a Consultant Systemic Psychotherapist who supported my systemic work with children and their families.

Roles and Experiences :

Formulation	Used ACT Case Formulation approach through the use of the Hexaflex. Formulating trauma history and presentation
Therapy Modality	Humanistic, ACT, EMDR, systemic work, Compassion Focused Therapy, Theraplay, Creative Therapies, groupwork
Multidisciplinary work	Range of multidisciplinary work with multidisciplinary colleagues. Worked with psychiatry, 3.5 services, Speech and Language therapist.. Contributed to peer supervision.
Multi-agency work	Contributed to Individual Education Plans. Contributed to child protection and child-in-need plans. Consultation to Tier 1 services (schools and social workers) Training to school staff on emotional regulation
Risk assessment	Followed agency procedure in assessing risks in young people with suicidal ideation.

Personal and Professional Development Activities

Voluntary work

Prior to starting on the course, I had been involved in voluntary work with two voluntary organisations:

- Anxiety UK Voluntary CBT Therapist

  Anxiety UK is a national charity that works to relieve and support those living with anxiety disorders. The organisation links anxiety sufferers with therapist who can work with them. One of the therapies offered is CBT.

- Marriage Care Voluntary Relationship Counsellor

  Marriage care is a national charity that offers relationship counselling, marriage preparation and relationship education to people who are in relationships to enable them build and sustain strong, fulfilling, healthy relationships. Services are offered irrespective of ability to pay.

I continued with the voluntary roles until the end of the 2nd year of the course and hope to resume with the voluntary roles once all requirements for the course has been fulfilled.

Personal Therapy

I have been engaged in my own personal therapy.

Professional Activities

- Attended the Annual Conference of the Division of Counselling Psychology in my first and second years (2013, 2014).
- Volunteered as an usher at the Annual Conference of DCoP (2014)

- Gave a talk at the Monthly meeting of the Black and Asian Counselling Psychology Group (BACPG)**.** Topic: What Counselling Psychology and Social work can learn from each other.
- Member of the BPS Child Protection Working group (2015).

Training

In the course of the three years training, I was privileged to access a number of workshops and seminars. These are:

Year 1:

- What works in treating chronic pain by Educare
- EMDR Child & Adolescent Training Level I – Joanne Morris-Smith
- Introductory course in Emotionally focused Therapy – Marriage Care
- Assessment & Formulation in Cogtnitive-Behavioural Couples therapy - BABCP

Year 2

- Lifespan integration Level 1, a therapeutic model that aims to heal the inner child
- Two-day Intermediate course in Acceptance and commitment therapy by Russ Harris
- Emotionally focussed Couples Therapy – Basic and Advanced Externships by ICEEFT/Marriage Care
- Introductory Level 1 course in Wholebody Focussing by Alex Maunder
- 8-week Mindfulness-Based Cognitive Therapy (MBCT) organised for CAMHS workforce
- 1-day interdisciplinary training in working with eating disorders organised by CAMHS multidisciplinary staff.-
- AIM2 Initial Assessment for Adolescents Who Display Sexually Harmful behaviour

Year 3:

- Trauma, Dissociation & Recovery: Working with Dissociative Identity Disorder and Complex PTSD by Positive Outcomes for Dissociative Survivors (PODS).
- Understanding Behaviour Change – Train the trainer course Organised by Royal society for Public Health (RSPH)
- Lifespan Integration Level 2
- Trauma Rewind Technique

Curriculum Vitae

Wemi Agboaye MA, MSc, DipPsych, MBPsS
o.agboaye@wlv.ac.uk

Background

Wemi is a Final year Trainee Counselling Psychologist. Prior to training as a psychologist, she trained as a social worker and is a registered social worker with the HCPC. She is also a qualified Cognitive-Behavioural Therapist working towards accreditation and is an EMDR Practitioner. Wemi has also had training in a range of other therapeutic approaches including Person-Centred, Focusing, Ego State, Inner-child work and Gestalt Therapy.

She has had over twenty years' experience of working with children and their families. The last 12 years of this has been mainly with Specialist Child & Adolescent Mental Health Services (CAMHS). More recently, she has worked with adults presenting with depression and a range of anxiety disorders She also has substantial experience of child protection work and is a trained and practising relationship counsellor.

Wemi's unique offering as a counselling psychologist is the integration of all the skills, knowledge and values she has gained prior to training as a counselling psychologist and during her counselling psychology training which has equipped her to offer a client-focused, humanistic underpinning to her work.

Main Roles and Responsibilities

In her current role as a specialist CAMHS Practitioner/ Trainee Counselling Psychologist, her main roles include assessment, case formulation and Therapy with children, young people and their families. She has experience of assessing young people who have been admitted to hospital for deliberate self-harm. Screening client referrals, conducting psychological assessments and offering individual, parent and family focus to psychotherapy.

Research Interests

- Knowledge and skills in working with dissociative features in clinical populations
- Effect of Childhood maltreatment on Individual development
- Cultural factors in parenting

- Factors that promote or hinder positive intimate partner relationship
- The impact of parental stress and domestic violence on children

Current Experiences:

January 2015 – ongoing	Specialist CAMHS Practitioner/Trainee Counselling Psychologist, Dudley & Walsall CAMHS Service
January 2012 – ongoing	Volunteer Relationship Counsellor, Marriage Care
April 2008 – ongoing	Volunteer CBT Therapist, Anxiety UK

Previous Experiences:

05/2013 – 12/2014	CAMHS Practitioner/Trainee Counselling Psychologist, Shropshire & Telford CAMHS
02/2013 – 01/2014	CBT Therapist/Trainee Counselling Psychologist, Birmingham Centre for CBT
07/2012 – 12/2012	CAMHS Practitioner/Trainee Counselling Psychologist, Coventry & Warwickshire CAMHS
05/2012 –27/07/2012	CAMHS Practitioner, Worcester CAMHS
01/2011 – 05/2012	Social Worker/ Advanced Social Work Practitioner, Sandwell Children Services
01/2009 – 04/2012 -	Associate lecturer, working together for Children KE312, The Open University
09/2008 – 06/2011	Practice Tutor, Birmingham University
09/2002 – 03/2010	Senior Social Worker/Senior Practitioner, Birmingham LAC CAMHS
07/99 – 08/2002	Social Worker/Senior social Worker Birmingham C, YP & Families Directorate

11/1995 – 09/1997	Residential Child Care Worker, Birmingham C, YP & Families Directorate
10/1994 – 02/1995	Care Assistant, Roseneath Residential Home for Elderly People
09/1993 – 08/1994	Children Ministries Coordinator, Peace Foundation Ministries, Ibadan, Nigeria, West Africa
09/1992 – 09/1993	Child Development Worker, Child Evangelism Ministry, Ilorin, Nigeria, West Africa.
09/1991 – 09/1992	Broadcaster, Broadcasting Corporation of Oyo State, Ibadan, Nigeria
09/9090 – 09/1991	Broadcaster, Ogun State Broadcasting Corporation, Nigeria

Education and Professional Qualifications:

- **Doctorate in Counselling Psychology**, University of Wolverhampton, To Be awarded in February, 2016.
- **Diploma in Psychology (Conversion for Post graduates)**, The Open University, (2011).
- **Professional Certificate in Management (Health & Social Care)**, The Open University, (2007).
- **MSc Applied Social Learning & Counselling**, The University of Birmingham, (2006).
- **Advanced Certificate in Practice teaching/Practice Teachers' Award**, The University of Birmingham, (2004).
- **MA/DipSW, Social Work**, The University of Birmingham, (1999).
- **BA (Hons) English**, University of Ibadan, Nigeria, (1990).

Continuing Professional Development/Professional Qualifications:

- Understanding Behaviour Change – Train the Trainer Course (2015)
- Psychometric Level A & B: Assistant Test User, Ability & Personality Tests (Portfolio to be submitted 2015)
- Wholebody Focussing (2014)
- Advanced Externship in Emotionally Focused Therapy (2014)
- Basic Externship in Emotionally Focused Couples Therapy (2013)
- EMDR Child Training (Part 1), (2013)
- Brainspotting Levels 1-2 (2013)
- Lifespan Integration Level 1 and 2 (2013, 2015)
- Certificate in Relationship Counselling (Conversion for Qualified Counsellors) (2013)
- EMDR Parts 1-3 and Assessment Day (2012)
- Parent Assessment Manual (PAMS) (2012)
- Primary Practicum in Rational Emotive Behavioural Therapy (2008)
- Attachment Styles Interview Practitioner Accreditation Course (2007)
- Triple p Level 4 parent training programme (Accredited provider training) (2007)

Professional Membership:

- British Psychological Society (BPS) Graduate Member with GBR
- In-training member, Division of Counselling Psychology (DCoP)
- Member, Division of Occupational Psychology (DOP)
- Member, British Association of Behavioural & Cognitive Psychotherapies (BABCP)
- Member, EMDR UK & Ireland
- Registered Member, British Association of Counselling & Psychotherapy (BACP)
- Registered Social Worker (HCPC)

- Working towards HCPC accreditation as a Counselling Psychologist

References:

To be supplied on request

.

RESEARCH DOSSIER

Dissociative Features in Clinical Populations: an Exploration, using Interpretative Phenomenological Analysis, of Psychological Therapists' Knowledge base and therapeutic perspectives

CONTENTS

Chapter 1 - Introduction

Chapter 1: INTRODUCTION

1.1. INTRODUCTION TO RESEARCH TOPIC

The current research dossier offers a doctoral student's journey into a topic area that is gaining increasing interest in psychotherapeutic practice and research – Dissociation. Sar (2011) places the prevalence of DID at about 1-3% of the general population and in 0.4% to 7.5% of psychiatric inpatients. The literature suggests that understanding dissociation can be challenging as there are diverse models and theories to understanding it and it often co-morbids with other clinical presentations (Spiegel, Loewenstein, Lewis-Fernández, Sar, Simeon, Vermetten & Dell, 2011). Given these myriads of challenges to understand the dissociative phenomenon, there is the impetus in the current research to understand how psychological therapists develop their working knowledge of the phenomenon.

1.2 DEFINITION OF TERMS

It is important to have a definition of terms to enable an understanding of what is meant by the term dissociation. Dissociation has been defined as "a disruption of and/or discontinuity in the normal, subjective integration of one or more aspects of psychological functioning, including but not limited to memory, identity, consciousness, perception, and motor control." (Spiegel, et al, 2011, p.19).

Spiegel, et al, 2011 describes the current diagnostic manuals – DSM 5 and ICD 10 as offering differing emphasis on dissociative features, with the DSM 5 emphasising psychological features of dissociation and having a separate section for physiological features. The ICD 10 on the other hand groups physiological features of dissociation and groups them under the category of conversion disorders.

The following terms are generally used to describe different types of dissociation and will be defined here:

- Depersonalisation/derealisation: this type of dissociative disorder involves feelings of derealisation: feeling that objects from the physical surroundings are changing in shape or size or feelings that other people are inhuman; and/or feelings of depersonalisation: feeling that one is detached from one's own life and mental processes or that one is viewing one's life as if it were a movie (Spiegel, et al, 2011).

- Dissociative amnesia: This type of dissociative disorder involves repeated periods when the individual with no memory difficulties or cognitive impairment, cannot remember information about themselves or about events in their past life, including skills that had previously been mastered. This is called dissociative fugue

when people find themselves in strange places without having recollection of how they got there (Spiegel, et al, 2011).

- Dissociative identity disorder (DID): DID is a dissociative process which involves dissociation from one identity and taking on another self-state or alter. The different personality states may or may not be aware of other states (Spiegel, et al, 2011).

- Conversion Disorders: Conversion disorder involves somatic symptoms which have their origin in psychological factors. Symptoms may involve blindness, paralysis, or other neurological symptoms (Cottencin, 2014).

1.3 STRUCTURE OF THE DOSSIER

The structure of the dossier is in line with the Wolverhampton University's School of Psychology's doctoral research handbook's suggestion that states:

> "There is flexibility in the structure of the research thesis as you are independent researchers and will develop your own thoughts on how your research is presented". (Page 17)

The layout of Chapters 2 – 4 reflects the layout of journal articles. They therefore each have distinct abstract and reference sections. It is envisaged that each of these chapters would be submitted for publication in either the *Counselling Psychology Review* or *the Counselling*

Psychology Quarterly. To this end, they have each been written in a format that meets the requirements of the journals. However, the version that would be submitted for publication would be summarised to meet the word limits for publication. The journals being considered are professional journals for counselling psychologists. Publishing in either of these journals would enable dissemination of the findings of the study to reach the counselling psychology community and offer contribution to the development of working knowledge of dissociation within the discipline.

1.4. OVERVIEW OF CHAPTERS

The current chapter offers an overview of the research dossier. The dossier consists of five chapters the first of which is this introduction. Chapter two will offer a systematic narrative review of the literature, chapter three will offer a detailed review of how the research methodology was chosen. In chapter four, the dossier will present the research report and chapter five will offer a critical review of the research process.

1.4.1. Chapter 2

Chapter 2 presents a narrative literature review of dissociation. The chapter provides a rationale for why this form of literature review has been chosen rather than other forms like scoping or systematic reviews. The review has been written in a form of secondary research, offering a broad

review of what has been found in the definitions, aetiology, diagnostic criteria and models of intervention used to work with dissociation in clinical practice.

A critical literature review is a form of research, in which the researcher explores data from secondary sources. For this chapter, there is a research question that drives the direction of the review. The research question is:

"What is known from the existing literature about dissociation, its prevalence in clinical populations and what therapy approach psychological therapists use in working with it?"

The review of the literature found that dissociation has historically been a contentious presentation in western medical, philosophical and psychological traditions. It was interesting to note that the current debate between the different models of dissociation dates back to at least the 16th century. The section on historical background to the study of dissociation details this. One interesting finding was the finding that dissociation was historically perceived to be specific to be a gender specific feature relating to disturbance in women's uterus. Given what subsequent studies have found about the relationship between dissociation, trauma and attachment, it appears confounding that for a significant period, females who have

experienced traumatic experiences were re-traumatised by the form of intervention they received from medical professionals.

The role of culture in the understanding of dissociation is also explored. Thus the literature suggests that dissociation presents itself in different ways in diverse cultures and in different periods. This extends the understanding of dissociation beyond western philosophical and psychological understanding.

The evolution in the understanding of dissociation is further shown in the diagnostic manuals, International Classification of Diseases (ICD) and the Diagnostic Statistical Manual (DSM). The Literature review explored how the two manuals have evolved in the language and description of dissociation over the years.

The review explored the prevalence of dissociation in the general and clinical population with dissociation being found to be related to many other clinical presentations. The review also identified the different models of dissociation and the convergence and divergence between these. Some of the models highlighted in the literature include, the structural theory of dissociation, socio-cognitive model, the trauma model, the attachment model and the fantasy model. The therapeutic approaches therapists have used to work with dissociation were also identified. The

findings suggest that therapists usually utilise an integrative approach to working with dissociation.

1.4.2. Chapter 3

In chapter three, the focus is on a critical exploration of the Research Methodology. In some practitioner doctoral studies, this section is subsumed under the same chapter as the research report. However, the current research dossier offers a distinct chapter to the process of deciding on a research methodology. This is because deciding on a research methodology was a tasking process which required informed knowledge of the different quantitative and qualitative approaches and understanding why Interpretative phenomenological analysis (IPA) is the methodology of choice. The chapter explored the origins and the different forms of phenomenological research, including descriptive, embodied, existential approaches, noting some of the debates between different approaches and also explores the strengths and limitation of IPA.

1.4.3. Chapter 4

Chapter 4 is the Empirical study. This chapter will begin with a brief review of the literature and the rationale for the study. It will then go on to discussing the methodology and research design. Given that a case has already been made for the use of IPA in chapter 3, this section is brief.

The current study is a qualitative exploration of psychological therapists' understanding of dissociation, where their knowledge comes from and how they work with these within therapy. The study focused on specific research questions. These are:

- What theoretical framework underpins therapists' understanding of Dissociative Features?
- How do therapists assess and treat dissociation?
- Which influences inform the approach individual therapists take to working with dissociation?

Cresewell (2009) states that research questions are what drive choice of methodology. As the current study aims to explore how psychological therapists develop their working knowledge of dissociation, the research questions indicate the need for a qualitative methodology.

The chapter offers a reflexive section on the role of the primary researcher in the study. After this, the chapter provides a section on the research findings. Four superordinate themes each with four subordinate themes were identified. These themes looked at the influences on the journeys of the participants from novice to experts, what influenced their search for knowledge and the different means through which they accessed working knowledge of dissociation.

The findings also include how participants work with dissociation, the theoretical underpinnings to their understanding of dissociation, the influence of supervision and worksettings. Finally, the findings show how participants go beyond the structure of their roles and trainings to make use of their personal agencies to evolve the use of what works for them in working with dissociative clients. Participants show a sense of common humanity and were able to relate to the dissociative features in their clients. All participants talked about the challenging nature of working with dissociation and emphasised the importance of self-care strategies to enable them to continue to work with clients who dissociate.

The chapter ends with discussion of the findings in relation to existing literature. It explores the strengths and limitations of the study, explore the implication of the study for policy, clinical practice and training of counselling psychologists and other psychological therapists and concludes with an emphasis on the contribution of the study to understanding the agentic role of psychological therapists in their development of working knowledge of dissociation.

1.4.4. Chapter 5

Chapter 5 offers a critical review of the research process and how this has been for the primary researcher. As a Research student of Black African

origin, she was drawn to the findings in literature that dissociation presents itself in different ways based on cultural expectations. The journey to completing the empirical research re-affirms the researcher's commitment to a pluralistic and integrative approach to work as a counselling psychologist.

1.5. CONCLUSION

This first chapter of the research dossier, has given a concise introduction to the doctoral thesis. It states the purpose of the study and its relevance and contribution to psychotherapeutic intervention with client population with dissociative features. The chapter gives brief definition of terms related to dissociation and offers insight into the content of other chapters contained in the dossier, including, firstly, Chapter 2, which is the Literature review, chapter 3, the research methodology chapter, which demonstrates that the decision to use IPA as the methodology of choice was made after careful and due consideration of all possible alternative methodologies, Chapter 4 which contains the empirical study offering an historical background, research design, findings, discussion and the conclusion to the study. Finally, chapter 5 offers a critical review of the process the student has taken in her development as a researcher.

1.6. REFERENCES

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1.7. LIST OF FIGURES AND TABLES

1.7. LIST OF APPENDICES

Chapter 2 - Literature Review

A Critical review of the Theoretical and Empirical Literature on Dissociative Disorders: Historical Background, Aetiology, Diagnosis and intervention in Clinical Populations.

A Critical review of the Theoretical and Empirical Literature on Dissociative Disorders: Historical Background, Diagnosis and intervention in Clinical Populations

Wemi Agboaye, Niall Galbraith & Abigail Taiwo

2.1 Content & Focus: *This study reviews the literature on the aetiology, diagnosis and therapeutic perspectives used to understand and undertake psychological interventions with dissociative disorders (DD). There has been an evolution in the understanding of dissociation in western psychology over the past century. For instance, the relationships between attachment disorders, complex post-traumatic stress disorder (PTSD) and dissociative disorders are increasingly becoming a topic of interest with researchers and clinicians alike. Dissociation is also increasingly found to be a factor in several clinical presentations. Relevant scientific literature, diagnostic criteria, guidelines and practice-based case studies were evaluated. There are different models for understanding the phenomenon called dissociative disorders. Mindfulness based approaches, parts psychology and attachment based approaches are used by many clinicians in psychological intervention with clients who present with the different forms of dissociation. What is clear is the apparent use of integrative approaches to working with dissociation.*

Conclusions: *The review concludes that as dissociative features have been found to be prevalent in a wide range of clinical presentations and there are diverse models offering explanations of what it is, it appears imperative that psychological therapists and other clinicians who work with clinical populations would benefit from having knowledge and skills in identifying, assessing and offering effective intervention to clients who may present with dissociation. Further research would be needed to explore how psychological therapists with working knowledge of dissociation came to develop their knowledge and skills. Such research would potentially have implication for training and development of mental health professionals.*

Key words: ***D****issociation, detachment, compartmentalization, depersonalisation, derealisation, attachment, complex trauma*

2.2. Introduction

Over the past three decades, there has been increasing interest amongst researchers and clinicians in the study of the phenomena called dissociation (Bucci, 2011; Binks & Fergusson, 2013). Whilst there has

been several studies on dissociation, defining the phenomenon and having an agreement on its utility in clinical practice has been an issue of contention amongst different researchers and theorists (Dalenberg, et al., 2012; Lynn, et al., 2014). Firstly, there is contention about the aetiology of dissociative disorders. Many researchers and clinicians have observed the dissociative phenomenon in clinical populations and posit that it has its origin in unresolved long-term exposure to traumatic experiences, For example, emotional, physical or sexual abuse and natural disasters, amongst others (Bucci, 2011; Brand, 2012). However, some other researchers have postulated that dissociation is therapist-induced and that the disorder is the result of clinicians imposing their views on dissociation on patients (Lynn, et al., 2012; 2014). Thus it is invaluable to explore the wider literature to understand the standpoints of different researchers and theorists, as understanding the apparent polarity of opinions on what dissociation is and how it originates is crucial for clinical practice.

Amongst those studies that recognise the authenticity and utility of dissociation, the concept has been found to be either pathological or non-pathological. In an Australian study, Irwin (1999) found that there is a relationship between pathological dissociation and childhood trauma. He found no such relationship between non-pathological dissociation and childhood trauma. This has implication for clinical practice in that clinicians would benefit from understanding when clients are merely presenting with

everyday forms of the phenomenon, for example day dreaming, and when it becomes unhelpful.

Amongst researchers that argue for the utility of dissociation, it has been noted that dissociative symptoms are as common and co-morbid with other clinical presentations (Liotti, 2006; Sternberg, 2008). Brand, et al., (2012a; 2012b) note that patients with Dissociative Disorders often first seek treatment for a variety of other clinical presentations including mood disorders, attentional and memory difficulties, substance abuse, affect regulation difficulties as well as psychotic and somatic ailments. This leaves their dissociative features undiagnosed for a considerable length of time after presenting to mental health services, thus delaying effective treatment (ISSTD, 2011).

Furthermore, there are studies that suggest that there is a relationship between dissociation, attachment difficulties and trauma, with some studies suggesting that dissociation is the legacy of repeated traumatic experiences, especially in the early years (Brand, et al, 2012a; 2012b). Understanding the underlying factors that inform dissociation in clients is of vital importance to psychological therapists.

The evolution of the understanding of the dissociative phenomenon in clinical practice can be seen in the changes made to the classification manuals Diagnostic and statistical manual (DSM and International classification of diseases (ICD). However, there appears to be a consensus that it can serve any of three functions. Firstly it can be a form of defense mechanism (psychoanalytic paradigm) Secondly, it can be seen as a lack of integration of mental processes (cognitive) and thirdly it can be seen as an altered state of consciousness (transpersonal) which can all be reactions to repeated stressful or traumatic situations (Brand, et al (2012a; 2012b).

There is some debate as to how broad or narrow the definition of dissociation should be. ISSTD (2011) described the process of dissociation as a normal process that is initially used defensively by an individual to handle traumatic experiences that evolves over time into a maladaptive or pathological process. Kennedy, Pearson and Kennerley (2013) sees this continuum as going from absorbed states which is common to all humans, for example, when watching a movie or reading a book to depersonalisation, dissociative amnesia, somatisation disorder and at the extreme end, dissociative identity disorder. Alternatively, some other theorists (for example, Brand, 2012; Brand, Lenius, Vermetten, Loewenstein & Spiegel, 2012; ISSTD, 2011; Steinberg, 2008) propose that dissociation is in categories and not dimensional.

Nijenhuis, van der Hart and Steele (2010) posit an hierarchical categorical model which sees dissociation as being on three levels – primary, secondary and tertiary dissociation. At the primary level, dissociation can be considered as a normal, helpful and protective strategy, in protecting the system from becoming overwhelmed. At the secondary level, there are persistent and repeated episodes of the phenomenon which impact significantly on normal functioning. At the tertiary level, dissociation is depicted by fragmentation of the personality and is called Dissociative Identity Disorder (DID).

Another categorical model of dissociation is compartmentalisation and detachment (Holmes, Brown, Mansell, Fearon, Hunter, Frasquilho & Oakley, 2005). In compartmentalisation, the individual may struggle to bring into conscious awareness, usually accessible information. This can lead to dissociative amnesia. Psychologically induced somatic symptoms may also be experienced. These are called somatoform or conversion symptoms. In contrast, Holmes, et al., (2005) define detachment as the experience of an altered state of consciousness in which the individual feel a detachment from self or the external world. This leads to what is termed as derealisation and depersonalisation.

What is clear in the study of dissociation is that every aspect of it from definition to forms and approaches to intervention is contentious and there are diverse positions as there are studies. This has the implication of being confusing to clinicians who may want to work with the phenomenon, hence the need for a synthetisation of the literature to understand the different theories and models of the phenomenon.

2.3. Rationale

The impetus for the current review was borne out of the first author's developing knowledge of dissociation. This knowledge has been derived from training and clinical experience which has stirred her interest in understanding more about the phenomenon. To this end, a qualitative doctoral thesis exploring how psychological therapists develop their working knowledge of dissociation is being undertaken. The current review aims to encapsulate the literature on dissociative disorders in order to provide a synthesis of its development and clinical application. It is envisaged that this would be relevant for clinical practice, policy-making and contribute to knowledge of areas for further research.

2.4. Research question

Specifically, the research question is "What is known from the existing literature about dissociation, its prevalence in clinical populations and what

therapeutic approaches do psychological therapists use in working with it?"

2.5. Material and Methods

Grant and Booth (2009) carried out a scoping review of the different forms of literature review. They identified the strengths and weaknesses of 14 different forms of reviews. For this study, a narrative review is more appropriate than other forms of review, (for example, scoping and systematic) as the field of dissociation is broad and there are diverse approaches used to understand it. Secondly, the aims of the current study address theoretical questions for which a narrative review is more suited. Furthermore, a narrative review allows for a bringing together of the diverse published literature on dissociation.

Furthermore, initial findings from studies indicate that psychological therapists utilise an eclectic approach to working with dissociation. A narrative review of the literature therefore offers a means of exploring wider relevant literature in the field of dissociation. This allows for the broad findings from research to be explored.

2.6. Ethical Considerations

Ethical approval has not been needed to carry out this review as only published data that were in public domain were used. However, certain

ethical considerations have been adhered to. Wager and Wiffen (2011) identified some ethical considerations authors of literature reviews need to adhere to. Whilst their primary focus was on authors writing systematic review for Cochrane journals, the suggestions are applicable to all authors of any form of literature review. The six suggestions are as follows:

1. Guidance on authorship: The primary author of the current review is the first author. She has been guided and supported by her research supervisors. As they have contributed to the writing by offering suggestions and guidance on the study, their contribution has been acknowledged by identifying them as co-authors. `
2. `Avoiding redundant/duplicate publications: The authors have been careful to ensure that no study is superfluous. Where authors have written more than one study, these are accurately represented by stating dates of publications.
3. Avoiding plagiarism: The authors have been careful to acknowledge all sources. The current review is an original narrative review of the field of dissociation.
4. Transparency: The authors have taken an impartial and objective stance in review of the literature. Bias is not given to any source or findings.
5. Ensuring accuracy: Findings are accurately explored and the review offers an unbiased representation of findings and results.

6. Flashing suspected Plagiarism: The authors not only commit to avoiding plagiarism, the current review also aims to note any plagiarism in any of the studies explored.

2.7. Search Strategy

The review involved a search of comprehensive primary and secondary literature (published and unpublished) suitable for answering the research questions. To achieve this, the search strategy involved searching for research evidence through multiple sources: These include electronic databases like google scholar, Psychology and Behavioural Sciences Collection, PYSCHINFO, reference lists and existing professional network websites, organisations involved with dissociation and attendance at conferences and training days on dissociation.

In view of the limited timescale for the study, only those studies published between 1990 and 2016 were included. The start date of 1990 was chosen because this time frame followed a decade in which there was a major shift in the recognition and exploration of dissociative features in clinical populations (van der Hart & Dorahy (2015). The search terms used to find appropriate literature were Dissociation, DID, DENOS, Complex trauma, attachment, depersonalisation and derealisation. The review adopted inclusion and exclusion criteria in determining which studies to include in the study, as shown below in Table 1.

Table 1: Inclusion/Exclusion criteria.

Parameters	Inclusion criteria	Exclusion criteria
Location	Any Country	None
Language	Studies written in English	Studies not written in English.
Time Frame	Studies published from 1990	Studies published before 1990
Population	Studies which focus on dissociative features in the clinical population	Studies which do not focus on dissociative features in the clinical population
Study type	Primary and secondary research using any design methodology	None

The decision to exclude studies not written in the English language means that this study's versatility is limited by the lack of access to the richness such studies could have potentially brought to the understanding of dissociation. However, without knowledge of diverse languages, it is difficult to access and make meaning of these studies. Making use of translation services could have been capital intensive and difficult for a doctoral researcher with limited funding. Furthermore, use of translators without adequate knowledge of psychological terms, could have potentially compromised the utility of such studies as important concepts could have been lost in translation.

2.8. Summarising and reporting the results

The review adopted a systemised review with narrative synthesis (Green, Johnson & Adams, 2006), which involves applying an analytical framework to all the identified studies. The Literature was critically evaluated to gain an understanding of the main emerging themes, for instance, the study population and the types of intervention. Primary and secondary research data formed the basis of the analysis, using a thematic approach. These are:

- Historical background to the understanding of dissociation
- Diagnostic criteria
- Theoretical perspectives
- The relationship between Dissociation and other clinical presentations
- Cultural, gender and developmental issues
- Case studies

2.9. Historical Background

There appears to be a consensus in the literature about the history of dissociation, at least in western psychology. Several sources credit the French psychologist Janet as being instrumental to the initial understanding of the link between trauma and dissociation in western psychology (Bob, 2003; Van der Hart & Dorahy, 2015). However, the historical origin of dissociation predates its association and link to trauma.

Kennedy and Kenerley (2013) and Loewenstein and Putnam (2004) provide a concise historical perspective on dissociation. They provide an overview from 16th to 19th century western society in which there were reported cases of possession and hysteria. Interestingly, the term hysteria was said to have been borrowed from the Greek word for uterus and it was originally seen as a condition that is specific to women who struggle to control their emotions.

More specifically, Loewenstein and Putnam (2004) offer a view of how the situated knowledge of the discourse on the dissociative phenomena has evolved in western scientific literature. This evolution, they opine, started in 1646, with Paracelsus shifting the discourse on dissociation from a purely religious discourse of demons and ghosts to the medical field. Since this period the debate on what dissociation is, how it presents, its causes and treatment have continued to generate disparate views. For example, Loewenstein and Putnam (2004) note that in 1811, Rush proposed that dissociation of the personality is the result of disconnection between the two hemispheres of the brain. Mesmer, the animal magnetist started the use of hypnosis, then known as somnambulism to treat patients who present with dissociation. Despine who was a student of Mersmer wrote systematic case studies and reports about multiple personality patients. However, animal magnetism did not have much credibility within the professional field as it was seen to be suggestive with

patients seen as merely acting out to satisfy what the magnetisers wanted them to do.

Loewenstein and Putnam (2004) note the influence of Charcot in synthesising the teachings of the magnetisers with those of the more accepted medical and psychiatric establishment. He was said to have believed hysteria was due to undiscovered pathology of the nervous system. Charcot's successors took divergent views of hysteria. For example, Babinski took the view that hysteria was caused by suggestion and could be removed by persuasion or counter-suggestion. Alternatively, Janet opined that the dissociative phenomenon is credible and his theory on the role of trauma in dissociation is regarded as the foundation for modem views of dissociation. Loewenstein and Putnam (2004) note that Janet and Freud were initially in agreement on the role of trauma in dissociation with Freud attributing the occurrence of childhood sexual experiences as being at the root of hysteria. However, he subsequently changed his thoughts and developing psychoanalysis which emphasises conflict between conscious and unconscious motivations and moved away from the dissociative forms of hysteria to somatoform experiences.

Kennedy and Kennerly (2013) suggests that the dominance of Freud's ideas in the early 20th century led to studies on dissociation falling under the radar. However, According to Kennedy and Kennerly (2013), the

occurrence of two world wars, saw psychiatrists documenting clinical presentations like shell-shock, which later became known as post-traumatic stress disorder (PTSD). This led to increasing interest in dissociation. The ongoing interest and debates have precedence in historical understanding of the phenomena (Van der Hart & Dorahy,2015).

2.10. Culture and Dissociation

There is growing awareness of the cross-cultural aspects of dissociation (Rhoades, 2006). Ross, Schroeder and Ness (2013) opine that there are cultural nuances in how dissociation is presented. For example, in cultures where having certain ways of being or beliefs like homosexuality or women being assertive, are seen as morally wrong, individuals in such positions may dissociate from their true self in order to maintain harmony with their society. Similarly, Somer (2006), in a comparative analysis, suggests that expressions of dissociation across different cultures and religions are dictated by the culture. He calls this culture bound symptoms which are not necessarily, pathological. Ross, Schroeder and Ness (2013) found that such culture bound syndromes, for example, spirit possession and Glossolalia (speaking in tongues) that may be seen as pathological forms of dissociation in the western paradigm, may not necessarily be pathological.

Seligman and Kirmayer (2008) propose that advancement in the understanding of dissociation would benefit from the integration of clinical and anthropological perspectives. They offer an integrative approach to understanding dissociation which moves away from lineal views of the phenomenon. This model takes into consideration the neuro-psychological and sociocultural processes involved in the construction and presentation of personality. The model which is grounded in a cultural neuroscience espouses the importance of the social-cultural context in the understanding of dissociation, thus bringing anthropological views on trance and spirit possession and clinical understanding of dissociative experiences together. What this study did not propose is how this interdisciplinary integrative model could be brought about. However, they give a compelling rationale for its importance, most especially, as individuals cannot be viewed in exclusion to their socio-cultural environment.

Within clinical populations, the differences in socio-cultural experiences of dissociation have been studied by researchers (For example, Dunn, Dunn, Ryan & van Fleet, 1998; De Maynard, 2009). Dunn, Dunn, Ryan and van Fleet (1998) in a quantitative study of male inpatients with diagnoses of substance abuse, found that there is a significant difference between African American (N = 48) and white participants (N = 48) in presentation of dissociation. The study found that even when participants from the two groups were matched for demographic details like age, employment and

marital status, the African American participants scored higher on three measures of dissociation (The Dissociative Experiences Scale (DES), The Questionnaire of Experiences of Dissociation (QED) and The North Carolina Dissociative Index (NCDI) than the white participants. However, they were unable to account for the differences in scores. More recently, De Maynard (2009) in a quantitative study of 236 participants of black African and black African Caribbean origin found that there was a correlation between participants' mental representation of their subjective experience of racism and their experience of dissociation. Whilst these two studies provide useful findings in highlighting the cultural differences in dissociative presentations, qualitative studies would be useful in understanding the subjectivity of these experiences.

2.11. Diagnostic Criteria

The utility of diagnostic classification like the World Health Organisation (WHO) International Classification of Diseases (ICD) and the United States' Diagnostic Statistical Manual (DSM) in mental health diagnoses has been a point of contention (Timimi 2002; Markon, 2013). Markon (2013) argues that not only are authoritative classification manuals not scientific, they can also limit the understanding of clinical presentations, as they do not represent variations in clinical presentations and offer limited understanding of the ontological and epistemological understanding of mental disorders from diverse cultures. Another argument against the

utility of classification manuals is their tendency to offer categorical representation of clinical presentations rather than dimensional perspectives. Markon (2013) further argues that authoritative classification manuals can limit advancement in research as researchers tend to base their understanding of diagnoses on the definitions and categorisations given by the classifications, thus limiting the use of pluralistic understanding of clinical presentations.

As an example of Markon's (2013) argument, several of the studies on dissociation have based definitions and categorisations of dissociation on DSM and ICD classifications (Brand et al, 2012; De Maynard, 2009; Farber, 2008; Prasko, et al, 2010). It has also been argued that classification manuals are ethnocentric and offer a predominantly western perspective on clinical presentations (Timimi, 2002). As a result, it is suggested that they provide limited utility in diverse cultures and serve mainly to benefit western drug companies (Timimi, 2002). This view whilst lacking in empirical validity has important implications for psychological therapists working with diverse cultures especially in understanding the clinical needs of individuals and prioritising these above statistical manual aided diagnosis.

In spite of the arguments against the classification manuals, some authors have argued for their utility. For example, Tyrer (2014) suggests that

classification manuals have made improvements to the diagnosis of clinical presentations, removing the onus from the subjective opinions of individual psychiatrists and offering peer-reviewed diagnostic criterion which are transparent and accessible to patients. Furthermore, he posits that having the option of choosing between the DSM which is prescriptive and the ICD which allows for the subjective opinion of psychiatrists enables informed choice in the diagnosis of clinical presentations.

What is evident is that the classification manuals have evolved, with the experts who developed them, taking on board many of the critiques of the manuals in order to offer a more dimensional perspective and greater appreciation of the role of culture and gender in clinical diagnosis. Whilst not without limitations, they serve as starting points for understanding the nosology of clinical presentations which can be a starting point for psychological therapists who aim to understand more about their clients' presentations.

The literature offers an historical perspective on how the classification systems have evolved in the understanding of Dissociation. Several authors have written on the utility of the conceptualisation of dissociation in both the DSM and ICD (Garcia, 1990; Dell, 2015).

The evolution of the understanding of dissociation can be seen in the language used to define and describe it in each edition of the DSM and ICD. For example, dissociation was described as hysterical reactions with two types, dissociative and conversion, in the first DSM which was published in 1952. Twelve years later, in DSM II (1968), the term changed to hysterical neurosis, dissociative and conversion types. The term hysterical comes from a psychoanalytic tradition and the change to hysterical neurosis, suggests dissociation was then seen as physical symptoms of psychological difficulties (Garcia, 1990).

The transition from the use of the term, hysteria, to describe dissociative symptoms came with the publication of DSM III when the term dissociative disorders with four types came into being. In DSM III the four types of dissocitive daisorders were amnesia, fugue, multiple personality disorder and somatoform disorders. Also notable is that it was in DSM III that dissociation became specified as a psychiatric disorder (Garcia, 1990). In the revised form of the DSM IV-TR (2000), in keeping in line with evolving understanding of dissociation, the term multiple personality disorder was changed to dissociative identify disorder. Furthermore, it groups dissociation into four categories, namely depersonalisation disorder, dissociative amnesia, dissociative identity disorder and dissociative disorder not specified (Dell, 2015a; 2015b).

The latest version of the DSM is DSM 5 (2013). This edition reviewed yet again how dissociation is classified and groups dissociative disorders into five categories namely: Dissociative identity disorder (DID), Dissociative amnesia including Dissociative Fugue, Depersonalisation/Derealisation disorder, Other Specified Dissociative Disorder and Unspecified Dissociative Disorder (DSM 5, 2013).

The DSM 5 and the ICD-10 take divergent approaches to the relationship of conversion disorders to dissociative disorders. The former treats them as separate conditions, grouping them under somatoform disorders and the latter treats them as conditions with similar underlying mechanisms (Dell, 2015). Another issue of divergence is depersonalisation and derealisation which in the DSM are dissociative disorders but are in separate categories in the ICD 10. This difference symbolises, only one of the many passionate disagreements that surround the disorders that have evolved from hysteria. The classification manuals are still some way off from describing fully, the nature of dissociation. Perhaps, the nature of the phenomena is unique to each individual that experiences it and clinicians and researchers alike will continue to play an important role in enabling understanding of dissociation.

2.12. Theories and models of Dissociation

The challenges of navigating the different views on dissociation

Literature search gives a wide range of theories and models of dissociation. These can appear bewildering and make dissociation even more difficult to understand. The basic issue to contend with in exploring models of dissociation, appears to be the need to consider if dissociation exists or if it is a creation of vested interests, for example, psychological therapists (Spanos, 1994; Lowenstein & Putnam, 2004). Secondly, if the phenomenon is considered to exist, there is the need to consider if it is pathological or non-pathological. Thirdly for the pathological forms of dissociation, there is need to explore the different models which have been used by researchers and clinicians to understand and work with these (Loewenstein et al., 2004)

Structural model of dissociation

Njenhuis, Van der Hart and Steele, (2004), Steele,Van der hart and Nijenhuis (2005), Njenhuis, and Van der Hart (2011) propose the structural model of dissociation of the personality. According to this model, everyone has an apparently normal part (ANP) of personality. The ANP is responsible for our ability to carry out normal daily activities and survival of the species. There is also the emotional part (EP) of personality. This part is the action systems for defence from major threat and survival of the individual. When the individual is integrated, the two parts have shared access to implicit and explicit memory. However, when the individual

experiences trauma, depending on the severity, they fragment. There are three levels of this model. These are Primary (simple PTSD and simple dissociative disorders), secondary (chronic and complex PTSD and dissociation) and tertiary dissociation (Dissociative Identity disorder). The level of dissociation depends on the severity and frequency of traumatic experiences.

Cognitive-Behavioural Approach to Structural Theory

Kennedy, et al., (2004), Harper (2011) and Kennedy (2013) propose a different form of structural dissociation. This is the cognitive-behavioural approach. The model draws from Beck's model of personality as well as Beck and Clark's stages of information-processing and personality systems (Kennedy, 2013).

Brewin, Dalgleish and Joseph (1996), in offering a cognitive model for understanding post-traumatic stress disorder, propose that there are two memory systems for storing traumatic events. These are the situationally accessible memory (SAM) and the verbally accessible memory (VAM). The SAM is non-verbal and operates at the subcortical level of the senses. The processing of information and memories at this level is rapid and sets the pattern for the reception of any new information. Thus if a fear response has been encoded in SAM, any new stimuli that are similar to that already encoded will instigate a fear response. The VAM on the other

hand involves cortical brain areas and processing of memories here is slower. Information received in the sub-cortical regions is passed to the cortical parts of the brain, thus allowing for more evaluation of incoming stimuli and filed in autobiographical memory. Based on this theory, Kennedy (2004) proposes three stages of structural dissociation namely automatic, within mode and between mode dissociation.

Attachment/Trauma Model

Some studies have suggested that dissociation is caused by attachment wounds and Bowlby's attachment theory can be understood through the phenomena of dissociation (Loitti, 2006; Steinberg, 2008; Bucci, 2012). Schore (2009) propose a developmental-attachment-neurobiological understanding of dissociation. He describes the physiological impact of dissociation in response to early trauma, and its effect on suicidality. He offered that the infant goes either into hyper-arousal (fear, aggression) or hypo-arousal (shutdown) when experiencing relational trauma. He posits that hypo-arousal occur when the infant is overwhelmed beyond what it can cope with and dissociates. This can lead to suicidality, as there is a shutdown of the right brain which brings on a sense of hopelessness. Dissociation is thus the primary defense mechanism individuals use to cope with trauma. In order to treat dissociation, the psychological therapist would therefore need to work with not only the mind but also the body.

Socio-Cognitive Model

Whilst there appears to be robust evidence for a relationship between trauma and dissociation, some studies have suggested that dissociation in clinical populations can be explained through the socio-cognitive model of dissociation (Spanos, 1994; Lynn, Lilienfeld, Merckelbach, Giesbrecht, & van der Kloet, 2012). The socio-cognitive model proposes that dissociation is driven by social-cultural context and individuals who dissociate do it to meet the expectations of powerful others, for example, psychotherapists (Spanos, 1994).

The debate on the utility of the trauma model and fantasy model was elaborated in the contributions of proponent of the trauma model on the one hand (Dalenberg & Carlson,2012; Dalenberg, et al, 2012) and the fantasy model on the other (Lynn et al 2012; 2014) who offer alternative explanation for dissociative symptoms. The fantasy model is an extension of the socio-cognitive model and posits that dissociation can be simulated and individuals who are the most at risk tend to be highly suggestible, fantasy prone, and influenced by their sociocultural environment. According to proponents of the model, dissociative presentation can be due to multiple factors and not necessarily trauma. These factors include the effects of drug, memory errors in the sleep–wake cycle, cognitive dysfunction and difficulties in distinguishing fantasy from reality (Lynn et al, 2014).

Gleaves (1996) whilst admitting the importance of considering the role of secondary gains like malingering on dissociative presentations nevertheless debunks the fantasy model and asserts that the social-cognitive model is based on a lack of adequate consideration of clinical presentations. Supporting Gleaves' (1996) assertion, Xiao, et al., (2006), in a quantitative study of clinical (n = 727) and non-clinical population (n = 618) in China found that pathological dissociation does exist in the country. Participants were administered the Chinese versions of the Dissociative Experiences Scale and the Dissociative Disorders Interview Schedule. They found that there was reported history of childhood sexual and physical abuse in participants who experience dissociation, thus confirming the tauma model of dissociation. However, this result was not statistically significant as only 24 participants report having dissociative experiences.

Offering a conciliatory stance, Castillo (1994) whilst agreeing to a socio-cultural explanation for dissociative features, argues that its root lies in early childhood trauma and that whilst in some cultures, for example South Asia, it can be seen as spirit possession, in western cultures it is seen as dissociation. Thus one culture sees dissociation as multiplicity or division of self-states, the other sees it as possession by ghosts and demons.

However it is important to note that the notion of dissociation and spirit possession is influenced by situated knowledge of time and place.

What is obvious from the literature is that lineal models of dissociation are artificial concepts whose purpose is to offer a simple understanding of the concept. It would appear that in reality, dissociation can be attributed to many factors. Even though, Lynn, et al., (2012) propose a fantasy model, they still found that there is a relationship between trauma and dissociative presentations.

2.13. Relationship between Dissociation and other Clinical Diagnoses

Vogel, Braungardt, Grabe, Sceinder and Klauer (2013) in a quantitative study of 74 patients with diagnoses of schizophrenia, found a relationship between dissociation and schizophrenia. They found that the type of dissociation which participants report depend on the symptoms which they have, with patients with positive symptoms of schizophrenia reporting detachment whilst those with negative symptoms report compartmentalisation.

Pica Beere and Maurer (1997) offered a theoretical stance, reporting an association between dissociation and obsessive-compulsive disorder.

They related both clinical presentations to inflexibility in the organisation and integration of cognitive and perpetual experiences, more especially as individuals who experience either of the presentations, usually have difficulties with attention, responding to changes in the environment and assimilating novel information into pre-existing schemas.

More recently and of empirical value, Prasko et al (2010) found that there is no relationship between the experience of diagnosis of dissociation and OCD. In a study comparing 54 patients with diagnosis of OCD and 124 individuals with no OCD diagnosis, they found that the healthy controls participants exhibit more dissociative symptoms than participants with OCD. However, they found that within the OCD participant sample, there is a correlation between the experience of dissociation and severity of depression and anxiety.

It may be that different types of OCD presentations have different relationship with dissociation. Rufer, Fricke, Held, Cremer and Hand (2006) in a study of fifty patients with OCD, found that there is a relationship between OCD symptoms and dissociation. However, the extent of the relationship is dependent on the form of OCD. They administered the short version of the Hamburg Obsessive–Compulsive Inventory and the Dissociative Experience Scale (DES) to all participants. Correlation analyses and multiple regression analyses were performed to

evaluate the relationship between OCD symptom dimensions and dissociation. They found that the checking dimension was most strongly related to dissociation, followed by the symmetry/ordering and obsessive thoughts dimensions. In contrast, no significant relationship was found between dissociation and the washing/cleaning, counting/touching, and aggressive impulses/fantasies dimensions. Only the checking dimension showed an independent positive correlation with dissociation. The findings suggest that there might be a specific link between checking behaviour and dissociation in OCD, more especially as checking compulsions seem to be associated with amnestic dissociation.

Several studies have found that there is a link between dissociation, self-harming and borderline personality disorder (Brodsky, Cloitre & Dulit, 1995; Zananimi, Rusera, Frankenburg & Hammen, 2000; Stiglmayr, 2008). Zananimi, Rusera, Frankenburg & Hammen, (2000) found that people with borderline personality disorder show higher symptom of dissociation than controlled study. In a controlled trial study of 290 participants with diagnosis of borderline personality disorder, administered the DES. They found that 32% of participants had a low level of dissociation, 42% a moderate level, and 26% a high level similar to that reported by patients meeting criteria for posttraumatic stress disorder (PTSD) or dissociative disorders. They found that participants in the control group, had a significantly different distribution of overall DES scores with 71% reporting a low level of dissociation, 26% reporting a

moderate level, and only 3% reporting a high level. In addition, borderline patients had a significantly higher score than the controls on 21 of 28 DES items and a significantly higher overall DES score, as well as the score on the 3 factors that have been found to underlie the DES, absorption, amnesia, and depersonalisation. The results of this study suggest that the severity of dissociation experienced by borderline patients is more heterogeneous than previously reported. They also suggest that borderline patients have a wider range of dissociative experiences than are commonly recognised, including experiences of absorption and amnesia.

Farber (2008) drawing from an example of long-term work with an adult female with history of abusive parenting and self-harming, drew from the psychoanalytic tradition in understanding the effect of attachment difficulties and absence of a secure base on experience of self-injurious behaviour. In the work with the client, Farber worked with his client, acting as a secure-base for her and modelling to her that someone is interested in meeting her psychological needs. The therapeutic relationship led to improvement in her marital relationship and led to reduction in the desire to self-harm. Farber (2008) suggests that this is because where here there is secure attachment, even if it starts within the therapeutic relationship, there is no need to internalise self-destructive introjects.

Brand, et al., (2012a) carried out a longitudinal naturalistic observational 30-month follow-up study of an international sample of patients with dissociative disorders to determine if treatment provided by community providers was associated with improvements in symptoms and adaptive functioning. The patients were diagnosed with dissociative identity disorder (DID) and dissociative disorder not otherwise specified (DDNOS). The patients and their therapists completed surveys at study entry and at 6, 18, and 30-month follow-up. At the 30-month follow-up, 119 of the original 226 patients completed the surveys. Results showed that patients report decreased levels of dissociation, posttraumatic stress disorder symptoms, general distress, drug use, physical pain, and depression over the course of treatment. Similarly, therapists report that patients engaged in less self-injurious behaviour and had fewer hospitalizations and adaptive capacities over time. These results suggest that treatment provided by therapists who have training in treating dissociative disorders appear to be beneficial across a number of clinical domains.

In another study, Brand, et al., (2012b) carried out a survey of the practices and recommended treatment interventions used by 36 Therapists whom they consider to be experts at treating patients with DID. Results showed that participants recommended a staged treatment consisting of three phases. Firstly, they advocated emphasising skill building in development and maintenance of safety from dangerousness to self or others and other high-risk behaviours, as well as emotion

regulation, impulse control, interpersonal effectiveness, grounding, and containment of intrusive material. Secondly, they recommended specific trauma-focused cognitive therapy to address trauma-based cognitive distortions. Thirdly, they recommended identifying and working with dissociated self-states beginning early in treatment. They advised the use of exposure or abreaction techniques, modified to ameliorate any risk of overwhelming patients.

de Zueletta (2009) posits that an understanding of attachment and its disorders is useful in understanding, managing and treating complex PTSD and dissociation. She suggests that the distinction between the diagnosis of complex PTSD and that of borderline personality disorder, which can be seen as a dissociative disorder, is insubstantial as both can be seen to result from deficits in attachment relationships (de Zueletta, 2009). De Zueletta (2009) further gives rationale between attachment styles and the presentation of complex PTSD and dissociative disorders. She offered that an infant's traumatic relationship with an abusive or unavailable caregiver can lead to the development of anxious disorganised attachment style which in turn can result in complex trauma and dissociative characteristics (de Zulueta 2009).

2.14. Official Guidelines and Treatment Approaches

The National Institute for Clinical Excellence (NICE) which is the UK agency with responsibility for producing official guidelines for the treatment and management of clinical presentations has not yet produced any guideline for the dissociative clinical presentations. The phenomena are currently grouped along with complex post-traumatic stress disorder (NICE, 2005). What is clear is that NICE (2005) recognises that the origin of the conditions is in childhood. Whilst NICE recommends trauma-focused CBT and EMDR as first line treatment of choice for Post-traumatic Stress Disorder (PTSD), it does not give any specific guideline for the treatment of dissociative disorders, complex PTSD and attachment disorders. The treatment approaches for these conditions are therefore based on clinical case studies.

In the absence of official guidelines, ISSTD provides guideline for effective assessment and treatment for adults with clinical presentation of dissociation. The guideline recommends that the primary treatment for dissociative disorders is phase orientated, individual psychodynamic orientated psychotherapy on an outpatient basis. Similarly, Potgieter-Marks, Sabau, and Struik (2015) produced a treatment guideline for dissociation in children and adolescent. This guideline was produced under the umbrella of the European chapter of ISSTD, European Society for Trauma and Dissociation (ESTD). Whilst there are similarities with the guideline for adults, for example the recommendation for a phased

oriented approach there are also important differences, for example, the importance of working with significant adults as co-clinicians.

The relationship between disorganised attachment styles, complex PTSD and dissociative disorders, points to possibility in developing similar treatment models for aspects of their presentations. Treatment for dissociation can be a component in the treatment for of attachment disorders and Complex PTSD. This is more so because dissociation is a symptom of both disorders (Courtois & Ford, 2010). Connor and Higgins (2008) developed a treatment for complex PTSD in which dissociation symptoms are addressed. The construct of Complex PTSD includes affective modulation issues as well as identity issues. Dissociation may be adaptive at the time of trauma, but once the threat is no longer present, can present a variety of problems. Therefore, it is important for clinicians to develop treatment strategies that incorporate treatment of dissociate symptoms when the client presents with such problems.

Traditional talk therapies like psychoanalytic and cognitive-behavioural therapy, systemic therapy and the humanistic approaches have been found to offer limited efficacy (Brand et al, 2012). More recently third wave therapies like Dialectical behavioural therapy, acceptance and commitment therapy (ACT), compassionate focused therapy(CFT) and mindfulness-based cognitive therapy (MBCT) are gaining popularity

amongst therapists (Hofmann, Sawyer & Fang, 2010). Gilbert (2013) proposed a compassion-focused approach to dissociation in which an evolutionary perspective is used to understand how the human mind reacts to threats. He integrated attachment theory into his model of understanding the importance of the caregiver to the development or lack of development of an infant's attachment and bonding systems. When these are not developed, individuals dissociate. The CFT approach aims re-integrate self-states through development of self-compassion and a mindful approach to relating with affect. Similarly, Neziroglu and Donnelly (2013) explored an acceptance and commitment therapy based approach to working with dissociation. They acknowledge that the efficacy of this approach is yet to be proven. However. they suggest that using the mindfulness based-orientation to the six aspects of ACT – seeing self as context, defusion from cognition, expansion of emotions, knowing what one values in life and being willing to live true to one's values, all create potential to enable clients to orient to their immediate environment and state.

Therapy approaches which focus on integrating traditional forms of psychotherapy with newer approaches are beginning to gain ground for their efficacy in treating dissociation and attachment wounds (Lamagna, 2011). These include Shapiro's (2001) Eye Movement Desensitisation Reprocessing (EMDR) and Schwartz's (1995) Internal Family Systems (IFS), which is a form of ego state therapy. Whilst these approaches are

gaining widespread adherents, there is no evidence base for their efficacy in treating dissociative disorders.

EMDR has an evidence base for being effective in treating Post traumatic stress disorder, it is however increasingly being used to treat a myriad of other clinical presentations (NICE Guideline, 2005). Ross (2012) proposes that what makes EMDR effective in working with dissociation is that it is based on a trauma-dissociative model. van der Hart, Groenendijk, Gonzalez, Mosquera and Solomon (2013) propose a three-phase EMDR trauma model of dissociation which goes through the stabilisation, processing of traumatic memories and integration of the personality (Steele, Van Der Hart & Nijenhuis, 2005).

There appears to be a paucity of literature on systemic psychotherapy and Dissociation. One study, Pais (2009) offers a systemic approach to working with dissociative identity disorder. Using a case example, she explored how integrating systemic psychotherapy with internal family systems could be used to work with clients and their network to engage with the family systems and internal systems. This study shows again the eclectic nature of therapeutic interventions for dissociation.

Perhaps less acknowledged in the scientific literature but visible in transpersonal psychology is the shamanic practice of soul retrieval (Ingerman, 1991; Berman, 2008). Berman (2008) opines that when an individual dissociates, they lose contact with parts of their psyche. The role of the shamanic practitioner is to bring back to the body, the lost part. The question that tasks Shamanic practitioners is where the dissociated parts of an individual go. Ingerman (1991) contends that finding where dissociated parts go is beyond mainstream psychology and requires a psycho-spiritual approach. Thus the Shamanic practitioner takes on an altered state of consciousness which may be aided by drumming or psychoactive drugs to journey into other existences either below the known world or above it, to retrieve the dissociated parts.

Berman (2008) gave an insightful example of this practice in which his partner was in a coma and he engaged the services of a shamanic practitioner who lived in another country to bring back her soul to her body. The shamanic practitioner went on a journey and was said to have found Berman's partner standing beside her body not wanting to re-enter it. After being persuaded, she came back into her body. Berman (2008) reported that his partner regained consciousness. Whilst there are only anecdotal reports of the success of shamanic journeying for soul retrieval in working with dissociation, it would be useful for more studies on this ancient approach to be developed in order to establish its evidence base and provide culturally-appropriate psychological intervention for people of

diverse cultures who may be experiencing dissociation (Simmington, 2013).

2.15. Case Studies of Dissociation Treatment

Four case studies were identified. Farber (2008), Jaffee, Chu and Woody (2009), Kluft (2012) and Granato, Wilks, Miga, Korslund and Linehan (2015). These all report different approaches to working with the single cases they worked on.

Farber (2008) in her study described the work she did with Joanie who she saw for 8 years from age 30. According to Farber (2008), there is a relationship between dissociation and all forms of self-harm, including eating disorders and self-mutilation. According to her, self-harming is the individual's attempt to regulate themselves when they have adverse attachment relationship with primary care givers. Joanie had self-referred because of her self-injurious behaviour. Farber (2008) used an attachment-based multi-phase approach in her work with Joanie. She offered a secure-base for Joanie and overtime, Joanie developed a secure sense of herself and as she developed this sense of herself her need to self-harm abated. It is possible that the transformation in Joanie is due to the time taken to model and build a earned secure attachment with Farber, having worked over 8 years together, through individual face-to-face therapy and on demand access via telephone.

Kluft (2012) offer the case of a patient he treated with hypnosis. After briefly mentioning the case of an eight year old boy he successfully treated with hypnosis and who has remained integrated for thirty-two years, Kluft (2012) offered some technique he used to work with Gwen, a lawyer with a history of sexual abuse who was raped in law school and suffered head injuries. Her experience of rape as an adult brought back trauma memories of her childhood. Kluft (2012) described how he worked with the different self-states of Gwen, which he called “alters”. Using imagery and visualisation, he stabilised the alters and inducted shame reduction procedures. Kluft’s (2012) used an integrative approach incorporating hypnosis with psychodynamic and cognitive-behavioural strategies. He found that the benefit of incorporating hypnosis to therapeutic interventions is that patients’ self-states become more easily integrated.

Granato, Wilks, Miga, Korslund and Linehan (2015) offered an exploration of how they used Dialectical Behavioural Therapy with Prolonged exposure to work with 31 year old Charlene who was drugged, gang-raped and left for dead at age 12. Her family was collusive to her abuse and offered no support. Charlene described self-harming when dissociating. Treatment was focused on the single incident of gang rape.

The DBT PE protocol was utilised and Charlene was seen for 41 sessions. Treatment lasted for 10 months. By the end of the intervention, Charlene’s

urges to self-harm and commit suicide has reduced markedly. Granato, et al., (2015) proposed that the integrative use of DBT and Prolonged exposure has the benefit of reducing dissociative symptoms in patients with borderline personality disorder (BPD) and PTSD.

The four case studies described above all have in common that whilst having a primary theoretical approach, are integrative with at least one other model. This supports the notion that psychological intervention in dissociation is best done with integration of models (van der Hart & van der Kolk, 2004).

2.16. Discussion and implications for psychotherapeutic practice and research

The purpose of the current review was to offer a synthesis and analysis of what current literature offers in the understanding of dissociation and how psychological therapists work with the presentation. The literature suggests that understanding the concept of dissociation is challenging and has been of interests to mental health practitioners for centuries (Kennedy, 2014). The evolution of professional understanding of dissociation is exemplified in the evolving guidance given by the diagnostic manuals DSM and ICD (Dell, 2015). This evolution suggests that the concept of what dissociation is, is constantly in transition. van der Hart and van der Kolk, (2004) and Kennedy and Kennerley (2014) offer a succinct history of

dissociation in western psychology which indicates that the argument over what dissociation is has traversed almost three centuries. It appears that this evolution is not only about scientific reasoning but also has to do with power and position, with theories being propagated by influential theorists being given more credence than theories whose propagators are not as powerful. The literature indicates that this is probably what happened with Janet's trauma-induced dissociation theory and Freud's psychoanalysis. Janet's theory went under the radar for nearly a century and the discourse on dissociation only became more known in psychological discourse in the 1970s (Kennedy, et al., 2014).

The discourse on the utility of dissociation as a concept and as a clinical presentation is also evident in the literature (Loewenstein & Putnam, 2004; Lynn, Lilienfeld, Merckelbach, Giesbrecht & van der Kloet, 2012). These are not always complimentary and there are ongoing debates about what dissociation is and what it is not. In spite of this, the sheer number of practise-based evidence supporting the phenomenon means that it is important for psychological therapists and other mental health professionals to understand its presentation and how to work with it.

An interesting aspect of the findings is the significance of cultural aspects in dissociative features (Rhoades, 2006). This suggests a need for cultural competence in psychological therapists, more especially because what

induces dissociation might be culture-bound and the presentation might be missed in some clients if therapists are not aware of its many presentations and functions.

The study has shown that a common ground in the understanding of dissociation is still a long way off amongst researchers and clinicians. There are diverse models of dissociation and there is still contention on if there is such a phenomenon as dissociation and what form it takes (Loewenstein, et al., 2004; Njenhuis, et al., 2006; Lynn, et al., 2012). It is important for psychological therapists to have a well-informed understanding of what theories have informed their understanding of what dissociation is and to be able to appreciate a critique of these theories and alternative views. This would go a long way in enabling an effective outcome for therapeutic interventions.

Furthermore, the plethora of approaches has implication for the choices psychological therapists make in their work with patients, who have experienced extreme trauma and symptoms of trauma-related dissociation. There appears to be a paucity of evidence-based research into what works in treating dissociative symptoms. In view of the growing use of therapeutic models that have no evidence-base, it is important for clinicians to be able to collect evidence of what works in their intervention,

thus creating practice-based evidence that can then be tested through empirical research studies.

Counselling Psychologists and other clinicians have a role to play in providing practice-based evidence that could inform the knowledge of what works in practice. The integrative and pluralistic orientation of counselling psychology places its practitioners and researchers in a pivotal position to be able to assess the particular elements of their interventions that help in working with dissociation.

2.17. Strengths and Limitations

The current review has offered a broad scope on the literature on Dissociative disorders. This has meant that it has enabled a breath of understanding of the different conceptualisations of dissociation. On the other hand, this has meant that the review has not gone in depth, in critiquing the literature. As stated previously, this review is a narrative review and has offered a wide scope of the relevant literature. In line with other narrative reviews, the strength of this is that it has enabled a broad understanding of the discourse on dissociation. The limitation to the wide scope is that in-depth analysis of the literature is not given.

The literature whilst indicating a need for cultural competence in working with dissociation is limited in not exploring a differentiation in the clinical presentations of the diversity of clients who access services. These include taking into consideration how dissociation presents in people of different ages, ethnic groups, people with disabilities and gender. It is important for counselling psychologists and other psychological therapists to be aware of diversity issues and how these can lead to structural inequalities in clinical populations.

2.18. Implication for further research, policy and clinical practice

There are implications for further research. It would be useful for clinical practice and patient outcome to understand how psychological therapists develop a working knowledge of dissociation. This is more so as it appears that theoretical orientation appears to inform views on dissociation.

A study of how psychological therapists develop a working knowledge of dissociation would also provide insight into what practitioners are finding effective in their work on dissociation. This will contribute to policy guideline, for example NICE guideline which currently has no recommendation for psychological therapy for dissociation.

Furthermore, it will be useful to explore if psychological therapists use unimodal approaches or integrative approaches in their work with dissociation. This has implication for integrative psychological therapists like counselling psychologists who are able to draw from elements of specific approaches that work and integrate these.

A salient implication of the results of this review is that most forms of dissociation have their roots in attachment difficulties and early childhood trauma. This has implication for mental health and social policy as well as developing the remit of psychological therapists. A public health approach to intervention, in which psychological intervention is aimed at primary, secondary and tertiary levels can be useful. At the primary level, intervention is aimed at preventing dissociation before it occurs. This can be done at a population level by preventing exposure to for example, trauma, abuse and other determinants of pathological forms of dissociation. At the secondary level, intervention will aim to reduce the impact of identified pathological dissociative features. This is done by training psychological therapists to identify and provide intervention as soon as possible. Intervention at this is more so important as studies have shown that lack of appropriate intervention keeps people in mental health services for longer than necessary. At the tertiary level, intervention will aim to ameliorate the impact of enduring adverse effect of dissociation. As the Royal College of Psychiatry (2010) asserts, there is no public health without public mental health.

2.19. Conclusion

The current review has explored some studies that have been carried out on dissociative disorders. It has evaluated the evolution in the understanding of the concept, the relationship between the clinical presentation and other clinical presentations like eating disorders, psychosis, complex PTSD and attachment difficulties. It found that there is a relationship between trauma, attachment and dissociation. The three conditions also share the experience of having no official guideline or clear evidence base for their treatment. Additional research into clinical interventions with Dissociative Disorders is imperative more so, because despite its prevalence rate, few clinicians are trained with identifying its symptoms or providing treatment for it. Little empirical evidence exists about the treatment of dissociative disorders. Thus, practice-based evidence from the clinical literature would need to be further developed in order to develop evidence base approach to working with patients with symptoms of dissociative disorders. It concludes that given the complexities and the multiple meaning given to the concept of dissociation, it is important for further research to be carried out on how psychological therapists develop their working knowledge of the presentation.

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CHAPTER 3 - Research Methodology

A Critical Evaluation of the use of Interpretative Phenomenological Analysis (IPA) in Counselling Psychology Research

A critical evaluation of the use of interpretive phenomenological research methodology in counselling psychology research project

Wemi Agboaye, Niall Galbraith & Abigail Taiwo

3.1. Content & Focus

The current paper explores the process of choosing a methodological approach to a study on how psychological therapists develop their working knowledge of dissociative features in clinical population. Having chosen a research area, the first author worked with her supervisors to determine a research methodology. The process of deciding on a methodology went through exploration of nomothetic and idiographic approaches. It became clear that an idiographic approach will be best suited to answering the research question which is "how do psychological therapist develop their working knowledge of dissociation". Mixed methodology approach, deciding on grounded theory or phenomenological approach and finally exploring the different phenomenological approaches before settling on an interpretative phenomenological analysis as the method of choice for the research study. The paper concludes that IPA is an appropriate methodology for the research objective, which is to explore the subjective lived experiences of psychological therapists as they develop their working knowledge of dissociation. The approach offers a solid foundation in researching the subject area, as it is experienced by individual psychological therapists. This has the potential of contributing to further studies, based on other methodologies, which may be aimed at developing theories or generalising.

Key words nomothetic, idiographic, qualitative, phenomenology, interpretative phenomenological analysis,

3.2. Introduction and Background

Counselling Psychologists (CPs) in the UK are trained to be scientist-practitioners (Bury & Strauss, 2006). This requires that both trainee and qualified CPs need to be adept at drawing from and contributing to research in applied psychology and other relevant fields (Bury, et al.,

2006; Kasket, 2013). The current paper aims to explore the rationale for why an interpretative phenomenological analysis methodology was chosen in a study of how psychological therapists develop working knowledge of dissociation. A comprehensive review of the literature on dissociation had shown that dissociation is a complex phenomenon which has diverse theories, models and therapeutic approaches (Chapter two). One of the considerations that came out of the review is the need to understand how psychological therapists develop their working knowledge of dissociation. Given the complexities of understanding what dissociation is and the lack of consensus on its utility, one of the recommendations of the literature review is to explore how individual psychological therapists develop their working knowledge of dissociation.

The researcher and her supervisors considered many methodologies including nomothetic and other idiographic approaches, such as constructivist grounded theory (Chamazz, 2006) before settling on IPA. The decision to use IPA as the methodology of choice is based on its concern with the subjective lived experience of participants and inter-subjectivity of the researcher in making meaning of participants' data.

The current chapter aims to explore the utility of IPA. It has been proposed that it is Important for researchers to have a good understanding of their methodology and why they have chosen it (Kasket, 2012; West, 2013). Having a chapter which explores IPA in relation to other methodologies

offers the researcher the opportunity to consider and make informed decision on methodology of choice. The chapter will explore the different schools of phenomenology, highlight the perceived strengths and limitations of IPA and will conclude that whilst other methodologies might be useful in exploring the research question, IPA is a valid start point for understanding how psychological therapists develop a working knowledge of dissociation as it starts with the individual psychological therapists' subjective lived experience. Understanding the individual and the researcher's meaning-making participants' narratives is a useful start point for beginning to draw theories and/or make generalisations.

3.3. Deciding Between Nomothetic and Idiographic Methodology

West (2013) proposed that researchers can start considering what methodological approach to use by either exploring the different epistemological and ontological underpinnings of different methodologies, then choosing the methodology that best reflects ones' worldview. The second approach is starting by exploring the research questions and choosing a methodology that can best be used to answer the question.

The problem with the first approach is that like Kasket (2012) states, counselling psychology researchers and by extension all researchers in applied psychology would benefit from a pluralistic approach to research, in which researchers do not rigidly have a view of one methodology as being superior to others. Thus, a third way, in which researchers critically

evaluate how the epistemologies and ontologies of each considered methodology may help answer their research questions, would be the most functional approach to deciding on research methodology (Kasket, 2012; West, 2013).

Nomothetic (taken from the ancient Greek term for laws, nomos) research seek generalisable findings that uncover laws to explain objective phenomena. On the other hand, Idiographic (derived from the ancient Greek term for personal) research seeks to examine individual cases in detail to understand an outcome (Lyons & Coyle, 2007). Historically, research in psychology has been nomothetic. However, in recent years, it appears that research in the social sciences and in applied psychology in particular has diversified from the traditional quantitative methodologies and given more credence to qualitative research methodologies (Morrow, 2007).

Morrow (2007) opine that a qualitative approach to exploring a phenomenon is superior to a quantitative approach and that qualitative methodological approaches are more suited to counselling psychology research as they have more relevance to clinical practice. Alternatively and more conciliatory, Salvatore and Valsiner (2006) propose that nomothetic and idiographic approaches are dimensional rather than opposites. They detailed an historic account of how psychologists came to be on opposing sides of the debate on what researching psychology

should be about. According to them, it was Windelband's 1894, well-meaning but misplaced contribution to defining the place of psychology in the sciences that inadvertently led to the entrenchment of psychological researchers pitching themselves on opposing camps.

Salvatore, et al., (2006) suggest that Windeband's view of the difference between nomothetic and idiographic studies was based on the ideology of the Greek philosophers, Plato and his student, Aristotle. Whereas Plato saw knowledge as generalisable, unchanging and universal, Aristotle, whilst agreeing that knowledge can be generalisable, sees it as starting with the understanding of the individual rather than the universal.

Salvatore, et al., (2006) view psychological research as being best served with an initial focus on idiographic approach from which a nomothetic approach can then be developed. In their view pitching on either side of the debate is limiting to psychological research and both nomopthetic and idiographic studies can be complimentary rather than competing with each other. (Salvatore, et al., 2016). They see psychological research as dynamic and evolving, offering an open-ended cycle in which knowledge is constantly being constructed and not static.

The implication of this view for the proposed research is that the proposed study on exploring how psychological therapists develop their working knowledge of dissociation will focus on exploring the subjective

experiences of participants. However, there is the recognition that the study will only be telling a part of the whole story.

3.4. Epistemology and Ontology

There is a growing recognition that researchers in applied psychology need to have an understanding of the epistemological and ontological basis of their research methodologies and stance on research interests (Ponterotto, 2005; Kasket, 2012). Ontology concerns the nature of reality and being. It is concerned with understanding the form and nature of reality and what can be known about that reality (Willig, 2013).

Epistemology derives from ontology and is concerned with the relationship between the “knower” (the research participant) and the “would-be knower” (the researcher). Even within qualitative methodological approaches there are diverse ontological and epistemological stances. Thus it is imperative for the researcher to be aware of the assumptions about the nature and source of knowledge different approaches make before using them. For example, whilst phenomenological methodologies aim to explore the subjective lived experiences of individual (Smith, 2004; 2009), discourse analysis is more interested in exploring language as used in particular social contexts (Willig, 2013) and grounded theory is more concerned with evolving theories about the realities of human interactions (Chamazz, 2006).

3.5. Comparison of qualitative methodologies

Grounded theory and phenomenology are the most common approaches to qualitative research used by applied psychologists (Willig, 2013). Whilst the two approaches have much in common, for example, both methods explore real life situations, there are also salient distinctions, for example, whilst phenomenologists are mainly concerned with homogenous data which can range from one individual to data from multiple but similar sources, grounded theorists' aim is to compare and analyse data from many sources until a detailed understanding of the researched topic is known thus providing a means of generating theories.

Grounded theory and phenomenology are both evolving research methodologies. For example, after initially collaborating, the founders of grounded theory, Glaser and Strauss both developed their own strands of the methodology. Emanating from their theories is constructivist grounded theory (CGT) Chamazz, 2006).

There is a marked difference between Glasser and Strauss's objectivist grounded theory and that of CGT. Whereas, The former see Grounded Theory as an objective methodology, and aims to find objective realities about human action and interaction, Chamazz (2006) posits that all realities are socially constructed, there is no one reality and what is discovered is influenced by the worldview of research participants and

researcher. CGT can be considered as having more in common with IPA than the older forms of GT.

3.6. Exploring the Different approaches to Phenomenological Research

Husserl is traditionally seen as the pivotal force in the emergence of phenomenology (Laverty, 2003). For Husserl, phenomenology is the study of essence (Rutt, 2006; Laverty, 2003; Reiners, 2012). Husserl believed it was possible to reflect objectively on everyday phenomena. This became known as a science of the life world. Husserl suggests that researchers need to bracket and set aside their own experiences, in order to maintain objectivity and be able to go into the life world of participants and understand the essence of their lived experiences (Ruft, 2006; Reiners, 2012).

Subsequent to Husserl's view on phenomenology, other theorists have proposed modifications or alternate views on phenomenological studies. Understanding the similarities and distinctions between the different schools of phenomenology is therefore important for researchers doing phenomenological research (Giogi, 2006; 2010) For example, there are phenomenological studies that are mainly based on a descriptive level (Giorgi, 2010). There are those which explored embodied experiences and there are those concerned with meaning making from data.

In contrast to descriptive phenomenological research, hermeneutic phenomenological research is more interested in what is going on between the participant who is the knower of a given phenomenon and the researcher, who is seeking to know. Hermeneutics is defined as the theory or philosophy of the interpretation of meaning (Bleicher, 1980).The origin of the term hermeneutics is from Hermes who was described as the messenger god of the ancient Greeks. In order to deliver the messages of the gods to humans, Hermes had to understand both the language of the gods and the language of humans. This role of interpreter is crucial to being able to effectively communicate what the gods want known to humans (Mueller-Vollmer, 1986).

Researchers using hermeneutic methodology are more concerned with going beyond description to exploring the relationship between the researcher and the researched. The ability to articulate the subjectivity of the participant and make sense of this through the inter-subjectivity of the researcher is what makes the data clear for the researcher to be able to disseminate to readers (Mueller-Vollmer, 1986).

Reiners (2012) opine that it is important for phenomenological researchers to have a well-informed understanding of the different schools of phenomenology. He suggests that researchers' congruency when basing their research on the philosophical tenets of for example, either Husserl's descriptive or Heidegger's interpretive phenomenology is vital to the

credibility of any proposed research. Thus it is recognised that if descriptive phenomenology is the basis for a study, the researcher will need to bracket her preconceived notions about the research topic in order to be able to describe as objectively as possible the subjective lived world of the participant. If the study's aim is interpretation of the data, the researcher would not be required to bracket held views and would need to be reflexive on how these has informed the interpretation of data as the researcher does not have to suspend their own lived experience of the research topic.

There are many theorists of the Hermeneutic approach to phenomenology, for example Schleiermacher, Gadamer, Heidegger and Ricoeur (Rutt, 2006). Rutt (2006) credits Schleiermacher as being instrumental to bringing hermeneutical inquiry to wider use from the initial purpose of the interpretation of sacred and other difficult texts, to include the interpretation of all aspects of lived experience.

There are salient similarities and differences in how each theorist have positioned their view of hermeneutic enquiries. For example, Schleiermacher's hermeneutic consists of analysing the language of the text as well as seeking to understand its author's psychology. Gadamer whilst agreeing with the essence of analysing language, does not concern himself with understanding its author. His view is that what is important in

hermeneutic enquiry is a coming together of the text and the interpreter, not necessarily the author of the text (Rutt, 2006).

Table 1: Exploring the schools of Phenomenology

	Transcedental	**Hermeneutic**	**Existential**
Definitions	Descriptive Phenomenology	Interpretative Phenomenology	Existential phenomenology
Assumptions	transcendence subject/object divide Essence	humans are unique. Relationship between data and researcher Meaning formed in relationship Being and time	Concrete lived experience Perception Being and nothingness
Notable figures	Husserl, Giorgi	Heidegger Gadamer Ricoeur, Smith	Merleau-Ponty Satre
Role of Researcher	Objective	reflexive	Reflective
Methodology	Bracketing (Epoche) Descriptive	Reflexive Interpretative	Reflective, Interpretative, descriptive

The various approaches to the use of phenomenological approach in psychology research have yielded interesting and thriving debate on the approaches. For example, between Giorgi (2010; 2011) and Smith (2011). The two take a descriptive and interpretative view to phenomenology respectively. Descriptive and Interpretive are the two most common types of phenomenology. Descriptive focuses on describing what we know whilst interpretive focuses on describing and interpreting human experience. In

using the descriptive phenomenology method, a researcher is required to approach the data without prejudice. The use of epoche (bracketing of the researcher's own meaning-making) is crucial (Giorgi, 2010). It is also important for the researcher to show the participant a copy of the interview in order to confirm the meanings assigned to the experience (Wimpenny & Gass, 2000).

3.7. Interpretative Phenomenological Analysis (IPA)

Smith (1996; 2004) introduced a new qualitative methodology, IPA, belonging to the hermeneutic school of phenomenology as a method of attempting to resolve the debate between the social cognition and discourse analysis paradigms. Given its flexibility, with creative use, it looks at cognitive, emotional and non verbal aspects of the interaction going on between participant and researcher.

One fundamental assumption in IPA is that humans self-reflect (Smith, Larkin & Flower, 2009). The intention of IPA is for the researcher to explore and understand participants' self-reflection. This is done by investigating and making meaning of their individual experiences, perceptions and idiosyncratic views (Reid, Flowers, & Larkin, 2005). What makes IPA a phenomenological rather than a social-cognitive methodology is that it seeks to understand the subjective rather than objective experiences of participants' lived world. (Smith, Larkin, Flowers, 2009).

The primary author carried out an exploration of *Counselling Psychology Review,* the professional journal of Counselling Psychologists in the UK. This showed that over the five year period between 2011 and 2015, there was a yearly increase in the number of empirical studies published in the journal. The majority of the studies were based on qualitative methodologies. It is possible that Counselling Psychologists, as applied psychologists who work mainly from a humanistic and relational framework are more interested in starting the process of knowledge construction from the subjective experiences of individuals.

Table 2: Comparison table of Research Methodologies used in studies featured in Counselling Psychology review over a five year period

Year	Research Methodology	Number of Participants
/2015	Pluralistic qualitative approaches – IPA, Narrative and psychosocial	1
	Mixed Methods: Qualitative (IPA) and Quantitative	4
	Randomised Controlled Trial	
	Glaser and Strauss Grounded Theory	6
	Constructivist Grounded Theory (Chamazz)	11
	Quantitative	
2014	Mixed Methods: Quantitative and Thematic Analysis	6
	IPA	6
	IPA	
2013	IPA	10
	Narrative Analysis	10
	Thematic Analysis	9
2012	Mixed Methods: Quantitative and Grounded Theory	11
	Hermeneutic single case design	1
	Constructivist Grounded Theory (Chamazz)	9
	Hermeneutic single case design	1
2011	Grounded Theory	17

Majority of the contributors to the *Counselling Psychology Review* carried out IPA studies. Grounded theory appears to be the second most popular. Perhaps, a topic of interest for future research may be to explore how counselling psychology researchers make decisions on which methodology best suits their studies. For the counselling psychologist, the professional commitment to humanistic, integrative and pluralistic approaches to practice means that by its very nature, as the practice of counselling psychology is not tribal or territorial, so does its research base needs to embrace diverse methodologies. In so doing, topic areas for research would be matched to a methodology that fits what needs to be researched.

3.8. Strengths and limitations of IPA

The strength of IPA as a research methodology can be seen in its increasing use across the wide spectrum of applied psychology, for example health psychology (Brocki, 2006) and related disciplines, for example, nursing (Pringle, Drummond, McLafferty & Hendry, 2001). Willig (2013) opines that the emergence of IPA as a research methodology has helped open up phenomenological research to non-philosophers. Furthermore, according to Willig (2013), it has a defined set of procedures which nouveau researchers can follow to guide them in its use, whilst still being flexible enough to enable researchers to use their agency to evolve what works for them.

What Willig (2013) sees as a strength of IPA is seen as a significant limitation by, for example, Giorgi (2010; 2011). Firstly he contends that the methodology does not adhere to criteria for scientific enquiry in that its finding cannot be replicated. Secondly, he queried IPA's claim to having a phenomenological underpinning. According to him, IPA does not adhere to essential concepts of phenomenology. For example, he asserts that the use of the term bracketing or epoche, which is a means of achieving phenomenological reduction is not well articulated in IPA. He contends that using reflexivity whilst being useful is not what makes a qualitative study phenomenological and that phenomenological reduction requires adherence to husserlian principle of total suspension of whatever theories the researcher might have about the nature of the experience being explored to enable the essence of it to be revealed.

It would appear that Giorgi being a proponent of husserlian phenomenology was seeking fidelity to this approach. However, it is safe to contend that Husserl was himself critiqued by amongst others, his protégée, Heidegger, regarding the phenomenology of nature of experience. Perhaps their differing views was to do with their different backgrounds with Husserl coming from a mathematical background and Heidegger coming from a theology background. It is possible that Giorgi (2010; 2011) and Smith, et al., (2009) are simply looking at phenomenology through different philosophical viewpoints. From a

phenomenological point of view, the diverse position on what is phenomenological research points to the subjective lived world of researchers.

Willig (2013) posits that language precedes experience as it is language that is used to describe and often used to shape experience. IPA researchers would therefore need to be aware of participants' use and non-use of language as participants who have limited expressive language may have their lived experience dismissed, thus limiting the understanding of their lived experience.

Willig (2013) also takes issue with IPA's professed concern with cognition as according to her, this implies a Cartesian worldview which implies that knowledge is unchangeable. It can be argued that this is incompatible with phenomenology's traditional concern with pre-cognitive experiences. Indeed, all major proponents of phenomenology emphasised a move away from positivist worldview, opining that this is just one way of seeing the world (Laverty, 2003).

3.9. Double Hermeneutics – The Hermeneutic Cycle

The origin of double hermeneutic lies with the sociologist, Giddens (1982) who proposed that research with humans is unlike research in the natural sciences, as by virtue of the importance of communication and relationship human participants make meaning out of the outcome of research. Studies

are therefore not simply what is done to people, people in turn make meaning out of theories. This is unlike research in for example, chemistry which is a single hermeneutic discipline in that the chemicals researchers in this field study will still retain their properties. Psychological and sociological research on the other hand, involves human participants who are agentic and can influence and be influenced by the researcher or other external factors. Similarly the researcher can be impacted on and make meaning from what participants offer (Giddens, 1982).

IPA recognises that it is not possible to fully bracket the experiences of the researcher whilst interpreting data. Whilst participants engage in their own meaning-making, the researcher is also engaging in making sense of what the participants are revealing, thus the notion of double hermeneutics. Researchers' awareness and use of their own interpretations of these experiences makes for richer findings, enabling a more comprehensive understanding of what was going on in the interaction between the researcher and the researched, both being agentic and making-meaning together. Double hermeneutic enables the researcher to look beyond what is spoken to interpreting and making meaning of nuances that participants may not be consciously aware of (Smith, et al., 2009).

3.10. Conclusion

The current paper has given a critical overview of different methodological approaches to psychological research. It has provided a rationale for the

use of interpretative phenomenological analysis in a proposed empirical study. In conclusion, whilst the use of IPA has strengths in offering an interpretative account of individuals' subjective lived experiences; there are limitations to the use of the methodology. This is understandable as IPA does not presume to be able to answer all research questions.

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Chapter 4 - Empirical Study

How do psychological therapists develop their working knowledge of dissociative features?: An Interpretative Phenomenological Analysis

How do psychological therapists develop their working Knowledge of Dissociative features?: An Interpretative Phenomenological Analysis

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4.1 Abstract

Aim: *Whilst the empirical and theoretical literature on dissociation is vast, there is a paucity of studies on the exact processes psychological therapist take to developing their working knowledge of the phenomenon. The current study aims to identify and explore: (i) how therapists develop their working knowledge of dissociation, (ii) The theoretical framework and models that inform their work with dissociative clients and (iii) The implications of these on their clinical practice.*
Method and Analysis: Se*mi-structured interviews conducted with 8 psychological therapists, who each have at least 5 years working experience of working with dissociative clients, were transcribed and analysed using interpretative phenomenological analysis.*
Findings: *The study produced a large range of findings which are broadly organised into four superordinate themes. These are (i) Novice to expert, (ii) Search for knowledge, (iii) Working with dissociation and (iv) Use of self. Analyses of the findings suggest the prevalence of the structural theory of dissociation amongst participants. Approaches to working with dissociation are unique to individual therapists and can be informed by the work setting, supervision and other influences. Participants also use their own agency to evolve their practice, based on what they find to work. Access to support and self-care is crucial to therapists maintaining ongoing work with dissociation.* ***Conclusion:*** *The findings highlight the need for some level of knowledge on the processes of dissociation in pre-qualifying training, as this prepares therapists for subsequent encounter with dissociation in clinical practice. Whilst the study supports findings from the wider literature regarding psychological therapists' eclectic and integrative approach to working with dissociation, it extends this knowledge by identifying the particular influences on therapists' development as experts in working with dissociation. It also identifies factors that can challenge therapists' readiness to continue working with dissociative clients. The findings have implications for training, clinical practice and mental health policy. The limitations of the study are acknowledged and recommendations for future research are offered.*
Keywords: *Dissociation; trauma; attachment.*

4.2 Introduction

The Literature on Dissociation indicates that there are diverse theoretical perspectives to understanding the phenomena. Similarly there diverse treatment approaches (Chapter 2). The range of views on what dissociation is suggests that mental health practitioners and researchers have interest in understanding it. However, this has not made it easier to understand, as the varying opinions have made understanding the concept challenging and multi-dimensional (Kennedy & Kennerley, 2013). The evolution of professional understanding of dissociation is exemplified in the evolving guidance given by the diagnostic manuals DSM and ICD (Dell, 2015). This evolution suggests that the concept of what dissociation is constantly in transition.

Van der Hart and van der Kolk, (2004; Kennedy and Kennerley, 2013) offer a succinct history of dissociation in western psychology which indicate that the argument over what dissociation is has traversed three centuries. It appears that this evolution is not only about scientific reasoning but also has to do with power and position, with theories being propagated by influential theorists being given more credence than theories whose propagators are not as powerful. The literature indicates that this is what happened with Janet's trauma-induced dissociation theory and Freud's psychoanalysis. What the literature suggests is that Janet's theory went under the radar for nearly a century until the 1970s.

Chapter two offers an exploration of the significance of cultural aspects in dissociative features (Dunn, Dunn, Ryan & Fleet, 1998; De Maynard, 2009; Rhoades (2006). This suggests a need for cultural competence in psychological therapists, more especially because what induces dissociation might be culture- bound and the presentation might be missed in some clients if therapists are not aware of its many presentations and functions.

A common ground in the understanding of dissociation is still a long way off amongst researchers and clinicians. There are diverse models of dissociation and there is still contention on if there is such a phenomenon as dissociation and what form it takes (Loewenstein and Putnam, 2004; Njenhuis and Van der Hart, 2011; Lynn, Lilienfeld, Merckelbach, Giesbrecht and van der Kloet, 2012). It is important for psychological therapists to have a well-informed understanding of what theories have informed their understanding of what dissociation is and to be able to appreciate a critique of these theories and alternative views. This would go a long way in enabling an effective outcome for therapeutic interventions.

Furthermore, the plethora of approaches has implication for the choices therapists make in their work with patients who are have experienced extreme trauma and symptoms of trauma-related dissociation. There

appears to be a paucity of evidence-based research into what works in treating dissociative symptoms. In view of the growing use of therapeutic models that have no evidence-base, it is important for clinicians to be able to collect evidence of what works in their intervention, thus creating practice-based evidence that can then be tested through empire research studies.

Only two known studies have been found that addresses how psychological therapist view dissociation (Madden, 2004; Stokoe, 2014). The two studies are research projects undertaken as part of the requirements of doctoral studies. Both studies focused on Dissociative Identity Disorder (DID).

Madden's (2004) study was a quantitative study which explored scepticism and knowledge of DID in adolescent clinical population amongst psychologists. She administered the scepticism scale and case vignettes to psychologists on the APA division mailing list. The purpose of the scepticism scale was to find the level of scepticism amongst psychologists working with adolescents. Whilst the number of respondents were minimal (N= 634), she found that the hypothesis that psychologists would demonstrate scepticism about DID was not supported. The responses on the case vignettes indicated that DID was misdiagnosed with a greater frequency than schizophrenia and that features of DID were often

explained by other diagnosis, for example, depression, bipolar disorder and psychotic disorder amongst others. Madden's (2004) study suffered from paucity of participants which she acknowledged might be indicative of scepticism about dissociation. It was interesting that whilst participants acknowledged the presence of dissociation in the adolescent population they work with, many of the participants did not accurately diagnosed dissociation from the case vignette.

Stokoe's (2014) study was a mixed methods – quantitative and qualitative (constructivist grounded theory) study of how therapist make sense of DID. Particpants for the quantitative study were N = 138. In common with Madden's (2004) findings, Stokoe's (2014) found that whilst participants report understanding of DID, only 44% of them were able to identify the features of the presentation. It was interesting that majority of participants report using variants of cognitive-behavioural therapy approaches. For the qualitative study she interviewed eight therapists. She found that many of the participants apply staged approach to working with DID drawing on interpersonal, intrapersonal and systemic team approach and also working with other agencies who their clients have contact with.

What the two studies suggest is that working knowledge of dissociation amongst psychological therapists appear to be limited and amongst those who have working knowledge of the presentation, there are a wide range

of approaches to working with it. This is in line with previous studies (Chapter 2).

Working with a complex and often disputed clinical presentation has the likelihood of impacting on therapists' wellbeing. Colin and Long (2003) found that Health-care workers who work with trauma victims are subject to significant stress and are vulnerable to what is now known as 'secondary traumatic stress'. Secondary traumatic stress theory forecasts that professionals affected by secondary traumatic stress are at a higher risk of making poor professional judgements than those professionals who are not affected (Munroe et al. 1995; Pearlman & Saakvitne 1995, Stamm 1997). Conversely, secondary traumatic stress theory predicts that personal, professional and organizational support may provide protective factors to mediate against some of the risks relating to the development of secondary traumatic stress.

Orlinsky, Botermans and Ronnestad (2001) in a study of the influences on therapists' professional development, conducted a survey of 4,000 psychotherapists. They found that work-based interpersonal learning was a major positive influence of therapist development. Furthermore, experiential learning from working directly with clients, formal supervision and personal therapy were all regarded by participants to be of more influence to their development than formal academic learning, even

though this was also found to be valuable. The study also found that the training environment and work settings have influence on how therapists experience their development. They suggest that the implications of their findings is the need for psychotherapist training to involve substantial trainee therapist contact with clients and have access to consistent supervisory relationship in order to enhance clinical skills. Ongoing personal therapy was also found to be essential for therapists' development.

4.3 The current study

4.3.1. Rationale

The current literature on dissociation shows that whilst there is many studies on dissociation, studies on the knowledge base of psychological therapists and how they work with it is still evolving. The two doctoral studies explored in the literature indicate that even when therapists report that they have working knowledge of dissociation, many are unable to identify dissociation in case vignettes. Dissociation has been acknowledged to be a complex and contentious clinical presentation. The current study aims to bridge a gap in understanding the process psychological therapists go through in developing their working knowledge of dissociation. It is envisaged that this knowledge would help in preparing psychological therapists for work with dissociation and elicit the forms of

support needed by psychological therapists in order for them to continue working with the presentation.

4.3.2. The research question

The current study is a qualitative exploration of psychological therapists' understanding of dissociation, where their knowledge comes from and how they work with these within therapy.

Specifically, the research questions are:

- What theoretical framework underpins therapists' understanding of Dissociative Features?
- How do therapists assess and treat dissociation?
- Which influences inform the approach individual therapists take to working with dissociation?

4.3.3. Research design

The methodology used for the analysis of the data is interpretative phenomenological analysis (IPA) (Smith, 2006). Semi-structured interviews were conducted with participants, who were all psychological therapists with working knowledge of dissociation. The interview was designed to elicit the therapists' lived experiences and perspectives of how

they evolved in their knowledge of dissociation, and their experience of working with the presentation.

4.3.4. Rationale for using IPA in this research

The aim of the current research is to understand the experience of the individual. IPA methodology was chosen as it provides a framework for an in-depth exploration of each participant's subjective lived experience of working with dissociation. Chapter 3 explored and gave a justification for the use of IPA as a starting point to exploring the research questions.

Whilst Chamazz's constructivist grounded theory (2006) has been said to be similar to IPA, it departs from IPA in its quest to develop theories. It is possible that having completed the IPA study, the current study would be able to contribute to future studies and thus allow saturation to be reached and theories to develop.

Discourse analysis was considered. However, because of its focus on the use of language and how this informs reality, it was seen as not robust enough for the current study. The influence of language is of course part of IPA's consideration in analysing participants' data. IPA therefore offers more in terms of analysis than discourse analysis could offer in

understanding how psychological therapists develop their working knowledge of dissociation.

The ontological and epistemological assumptions as well as the methodological assumptions of IPA (Chapter 3) were viewed as being the most appropriate for the current study. The analysis of the interview data explored closely, the participants own words, their values and influences and gave opportunity or the researcher to offer an interpretation rather than just a description of these. Larkin, Watts and Clifton (2006) suggest that it is the researcher's commitment to construction of meaning, beyond description of participant's data that encapsulates the unique contribution of IPA to empirical research.

4.3.5. Reflexivity

In common with other qualitative methodologies, IPA takes a reflexive position regarding the role of the researcher (Willig, 2013; Berger, 2015; Shaw, 2016). The importance of reflexivity to qualitative studies cannot be overemphasised. Shaw (2016) suggests that reflexivity enables researchers to be aware of how their worldview can influence every aspect of a study, from methodological approach to how data is collected and analysed. Berger (2015) suggests that in offering reflexion, researchers need to be aware of their feelings, thoughts, social position in relation to not only the subject of study but also the participants. Crucial to ethical

research is the need to be reflexive of what one brings to the study and how these may impact of outcome (Berger, 2015; Shaw, 2016).

The current study is undertaken as part-fulfilment of the requirements of the doctoral study in Counselling Psychology of the first author. In line with guidance given by Smith (2010), the reflexive piece will be written in first person.

I am a 47 year old female of black African origin who was born in the UK and grew up in Africa before returning to the UK in my 20s. This cross-cultural background traversing distinct social environments has informed my worldview on different phenomena. For example, my experience as a black female growing up in a former British Colony, the social environment in which I have had to transform from conditioning to glorifying all things western to incremental appreciation of my own cultural heritage and diverse worldviews.

I transitioned into Counselling Psychology having initially trained and qualified as a social worker and cognitive-behavioural therapist working with children and their families. In my many years of working with clinical population, I had not had knowledge of dissociation until I went to train in Eye Movement Desensitisation Reprocessing (EMDR). This approach

required practitioners to assess for dissociation at the initial stages of intervention. As I became more aware of dissociation, I began to wonder how come I had not had knowledge of the presentation before training in EMDR. I reflected that it would be a worthwhile contribution to the field of counselling psychology and other psychological therapy approaches to research how psychological therapists develop their working knowledge of dissociation.

4.3.6. Participants

The participants in the study were drawn from a combination of those psychological therapists who responded to an invitation to participate on the professional network site, social media and direct approach of psychological therapists who were known to work with dissociation.

The inclusion/exclusion criteria for selection are that participants have working knowledge of dissociation and they have been working with dissociation for a period of five years. The criterion for five years was chosen as this offers a period in which therapists would have become embedded in their practise and can articulate their personal experiences.

2 participants were interviewed for pilot study and the feedbacks from these were used to modify the interview protocol. Two important learning

curves were gained from the pilot study. The first is the precarious nature of interviewing via skype and telephone. The reception was not clear and the researcher was unable to transcribe the data. This led to her travelling to interview most of the participants. Secondly in the second pilot, the researcher had been eager to tell the participant about her own knowledge of dissociation. On reflection, it is possible that this led to the participant withdrawing from the interview within 15 minutes. Learning from this, the researcher allowed participants more space to explore their own worldview without first talking about her own views. Smith, Flowers and Larkin (2009) stress the importance of researcher sensitivity to the interpersonal dynamics of data gathering and analysis.

8 participants participated in the main study. All participants are female. There were no male volunteers for the study. It is possible that this is because the field of psychological therapy is more populated by female therapists (Morison, Trigeorgis & John, 2014). 5 of the participants are of white UK ethnicity, one from Indian origin, one of Black African-Caribbean origin and 1 white American. The 7 participants from the UK live and work in both multicultural and rural parts of the UK. Participants' ages range from early thirties to early 60s.

The names of the participants have been anonymised. Only basic demographic information is provided so as to limit the possibility of

unwittingly giving undue hints about the identity of participants as the pool of psychological therapists able to talk about dissociation is limited. A summary of descriptive statistics of participants is listed in the table below:

Table 1: Participants' Characteristics:

Participant	Gender	Ethnicity	Age range	Professional Discipline	Theoretical Approaches	Years of Practice	Work setting
1 Anne	Female	North American	60 - 65	Psychotherapy	Integrative – EMDR, Body Psychotherapy	36 years	Private Practice
2 Beth	Female	White UK	40 - 45	Counselling Psychology	Integrative – Person centred, CBT, inner-child work	11 years	NHS
3 Ceyone	Female	Indian	55-60	Child Psychiatrist	Psychodynamic, EMDR	23	NHS
4 Diane	Female	White UK	50-55	Counselling Psychology	Integrative – Humanistic, CBT, Psychodynamic	16	Private Practice
5 Emma	Female	White UK	30 - 35	Clinical Psychology	Integrative – Attachment, Trauma model	5	NHS
6 Folake	Female	Black African Caribbean	55-60	Psychoanalytic Psychotherapy	Psychoanalytic Psychotherapy, African Psychology	31	Private Practice
7 Gail	Female	White UK	50 - 55	Clinical Psychology	Eclectic – CBT, Psychodynamic	24	NHS
8 Hannah	Female	White UK	55-60	Clinical Psychologist	CBT	33	Private Practice

4.3.7. Ethical Considerations

The study was subject to ethical review and was approved by the Research Ethics Committee of the School of Psychology, University of

Wolverhampton (see Appendix 1) for a copy of the approval letter. To ensure that participants were making an informed decision about participating in the study, they were provided with an information sheet to help them to make their decision about whether to participate in the study (See appendix 6 for participant information sheet). Each participant was given a consent form (See appendix 5). They were informed that they were able to withdraw their consent at anytime up to the point of analysis. All data were stored and encrypted and only accessible to the primary researcher and research supervisors. All identifying information was removed to enable anonymity. Following transcription and analysis, the audio recordings were destroyed to further strengthen confidentiality and anonymity.

4.3.8. Process of Data Analysis

Following transcription of the interview data, the researcher went through the analysis of each data one after the other. The process of analysis followed six steps as suggested by Smith, Flowers and Larkin (2009). These involved, firstly, familiarity with each participant data through immersion by reading and listening to each interview for extended periods of time. Secondly, preliminary notes and emergent themes, exploring the data at descriptive, linguistic and conceptual levels were developed (See Appendix 7 for excerpt of exploratory comments and emergent themes derived from a participant's data). Thirdly, having identified emergent

themes from each participant's data (See appendix 8 for stream of emergent themes from 4 participants), the analysis went on to fourthly, explore connections and abstract each emergent theme under relevant cluster of subordinate themes (See appendix 9 for 2 examples of this process). Fifthly, this process was applied to each interview data in turn, leading finally to exploring areas of convergence and divergence across participants' data and the subsuming of the subordinate themes under super-ordinate themes (see appendix 10 for table indicating areas of convergence and divergence). The identified themes were illustrated with quotes (see appendix 11 for Master table of themes for the participant cohort).

4.3.9. Interrogative themes

In common to other critical approaches to qualitative research, IPA adheres to the notion that all realities are socially constructed (Smith, et al., 2009). To this end, the analysis of the findings will be underpinned by an understanding of how the participants and the researcher are influenced by the context of the environment and time in which they train and practise. Holloway, Lucey and Phoenix (2006) identified four interrogative themes that may be used to critically explore qualitative studies. These interrogative themes have been used to offer critical depth and perspectives to the themes emanating from participants' data.

Firstly, Holloway, et al., (2006) identified the importance of power relationships in all human interactions. The analysis of the data will explore how the concept of power has informed the data. This can be inferred from participants' use of language and how they have been impacted on by the use of power.

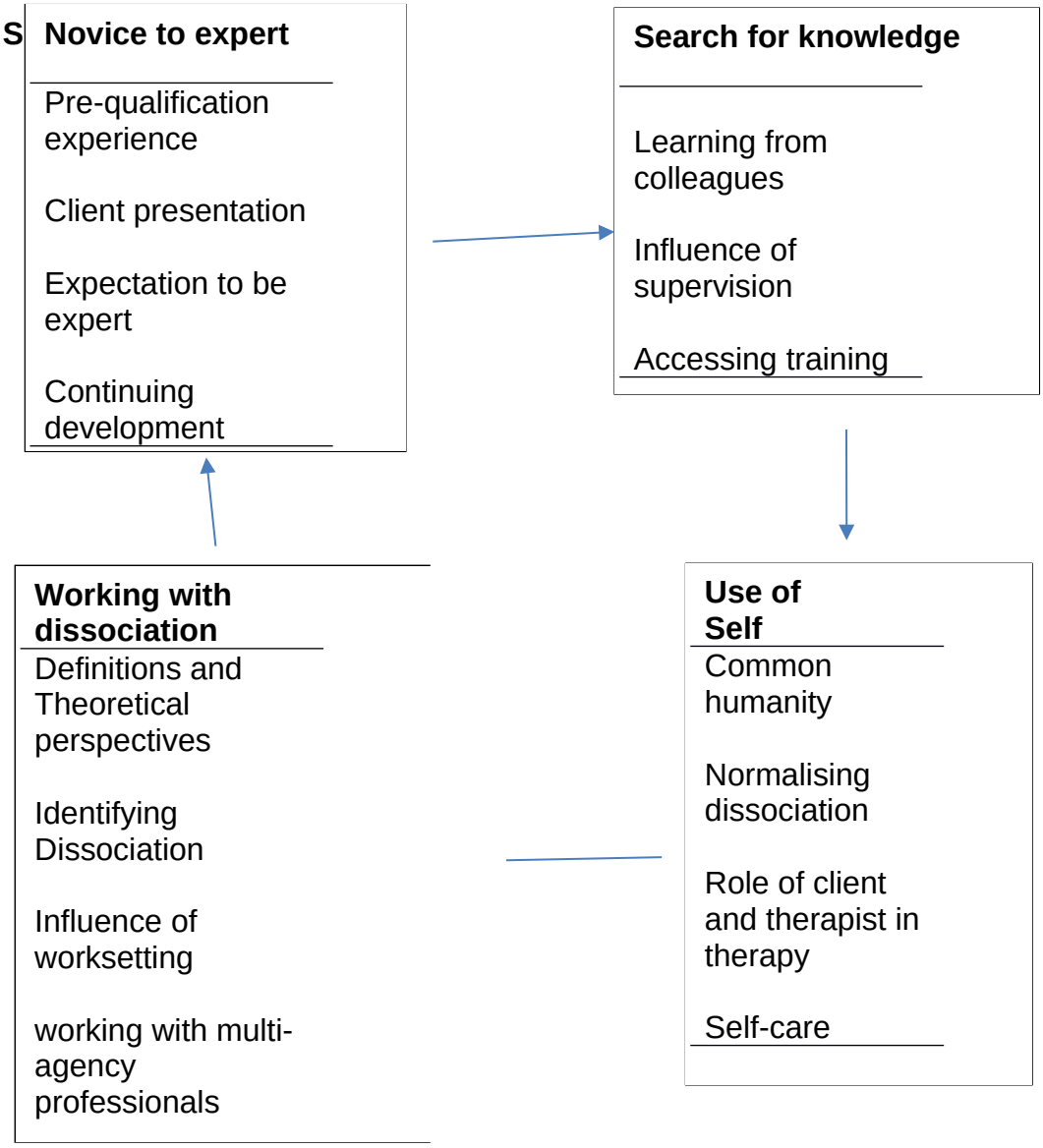
The second interrogative them is the concept of how the knowledge they have is situated in specific time and place. This was found to be helpful in situating participants' discourse in eras when particular models and theories of practise were dominant, how participants' social-cultural background has informed their views and how they have evolved as psychological therapists.

The third theme will look at the relationship between the individual and the social environment, taking a critical perspective in exploring how these have informed how they develop knowledge and skills in working with dissociation. This third theme is closely aligned with the fourth, which explores participants' use of their individual agency and how this is limited or enabled by the structure of their training and work environment in their development of working knowledge of dissociation.

4.4. Findings and Analysis

The following section will outline the key findings of the of the IPA analysis of the semi-structured interview. From the analysis of the data, four superordinate themes, three with four subordinate and one with three subordinate theme, were identified. Together, these themes provide a cohesive narrative of the journey participants have taken to developing a working knowledge of dissociation and factors that have enabled them to continue their journeys. The table below gives an outline of these:

Table 2: Diagrammatic representation of the Superordinate and S



4.4.1. SUPERORDINATE THEME 1: NOVICE TO EXPERT

Participants had varying experiences of how they have journeyed from the experience of being novices to being experts. Whilst some view themselves as experts, some with similar years of experience, suggest that they are still learning. The influence on how the participants see themselves in relation to journey into working with dissociation is illustrated in their views on the utility of learning about dissociation during their **pre-qualification training**, their **personal experience of initial encounter with dissociation** and how this impacted on them, the pressure they face from themselves and others to be **experts** and how these experiences led to their search for how they may develop their working knowledge of dissociation through their **continuing development** of knowledge of dissociation.

4.4.1.1 Pre-qualification experience: Dissociation in pre-qualifying training:

Participants' views on the importance of learning about dissociation on their pre-qualifying training, vary. Some talk about not having covered it during training, one talks about how it is impossible to learn about everything in pre-qualifying training and that what is important is to be able to learn continually, from your own experiences after qualification. Others talk of how on first encountering dissociation in their practice, they sought out colleagues who were more experienced and learnt from them.

For some of the participants who qualified as psychological therapists without any knowledge of dissociation, there appeared to be a sense of having been denied crucial aspects of clinical awareness:

> "Nobody said a word about trauma…nobody said a word about suicide and nobody said a word about dissociation." (Anne, Lines 884 - 885).

It appears that the "nobody" Anne was referring to were her lecturers. For her, dissociation is one of the most important aspects of clinical presentations that were not taught on her course. She indicated a gap in learning when dissociation is not taught in pre-qualifying training. Not having knowledge of what is important can be frightening and this is the sense one gets from Anne.

The opportunity to access training on pre-qualifying courses appear to be about time, place and trainees' sense of agency in identifying training needs. For example, Beth had an introductory session on dissociation in her pre-qualifying training:

> "And at the time (I don't know how it is now) we were allowed to request specific areas that we might like to have somebody come in and talk about." (Beth, lines 580 – 583).

Having had a taster session on dissociation on her pre-qualifying training; she was able to recognise it in her client, post-qualifying:

> "I knew of it from the training so when the little girl in particular that I was talking to, talked about having lots of different names and then they became personalities, it was easy for me to identify…It was how you went forward with it that was my stumbling block." (Beth, lines 557 – 562).

Beth's prior knowledge of dissociation enabled her to understand what was going on for her first dissociative client. However, it appears that knowledge is not enough to enable her work with the client, as she talked about her "stumbling block". This suggests that she still felt stuck about what to do. Knowing what she was observing was a hurdle jumped.

One participant who talks about having extensive training on dissociation on her training is Ceyone. The difference between her and other participants is that she is a psychiatrist, who had part of her training in a psychoanalytic specialist unit. For Ceyone, it was not her training as a psychiatrist that enabled her to experience working with dissociation whilst undertaking her training; rather, it was the situated knowledge of the setting of her clinical placement.

> "it was definitely taught as part of our psychodynamic/psychiatric training…" (Ceyone, lines 228 – 229).

Participants reveal different attitudes regarding the benefit of learning about dissociation in pre-qualifying training. Six of the participants felt it was an important aspect left out of training and two were ambivalent,

suggesting that not learning about dissociation was not crucial to pre-qualification training.

> "Saying that, the course could do a great module on dissociation. But then where does it stop because then what about the people who work with learning disabilities? Do they want a module on learning disabilities?" (Beth, lines 960 – 964).

Diane was more explicit about her view, with the use of metaphor of baking a cake. For her, the pre-qualifying programmes give the basics, learning about dissociation and other processes is about "extras" which can be learnt post-qualifying:

> "It's a question I've thought about. And the answer is I don't know, however I would qualify that by saying it's a bit like making a cake. Your training is: here are the basics, here's the flour, here's the eggs, here's the butter. It's up to you how you make the cake. You might want to add some extra cocoa powder. You might want to add some fruit. So your training gives you the basics, gives you the bones…It's when you've qualified, and you're out there that you then discover there's so much more to this." (Diane, lines 713 – 730).

Conversely, for some of the participants, some form of training in dissociation at pre-qualification level is useful. They see dissociation is an aspect of human experience which needs to be understood from the early stages of training:

> "If you keep a very open-minded stance on it, I would say it one of the most key principles that professionals need to be aware of. Without that, you don't have an understanding of human nature, maybe. How are you going to help a patient if you don't

> have an understanding of what is important to them?" (Ceyone, lines 587 – 597).

Ceyone use of the phrase "open-minded stance", suggests a tentative view of dissociative features. She appears to be saying dissociation is what therapists need to be aware of in case it presents itself in clients.

For many of the participants, the impact of not knowing about dissociation on their work with clients was that they worked for years with clients who were experiencing dissociation without recognising this:

> "I think people need to be aware of it much sooner. Because I went for years not really knowing what to do with lots of people. Imagine that at least they felt…I hope that those people felt they could speak to me, but obviously wasn't getting something about their experience, something major." (Gail, lines 975 – 981).

The lack of working knowledge of dissociation perhaps left Gail feeling like valuable time and effort was lost. Her narrative suggests that she felt not knowing about dissociation has meant she had not given good enough therapy interventions to her clients.

For Folake, having dissociation taught in pre-qualification training is not the answer to preparing therapists for working with dissociation. She suggests that returning to the traditional approach to training which at the time she was trained was more experiential than academic is the best

preparation for being a therapist. This and significant hours of personal therapy would help therapists attune to client's needs:

> "Psychoanalysts and psychotherapists originally, most of their training was about their own therapeutic experience…not about what they learnt in the classroom. I think we need to go back to that. It can't be about 40 hours of personal therapy and a million years in the classroom learning the theory about this and the other." (Folake, lines 1151 – 1168).

4.4.1.2 Impact of unusual client presentation

All participants report on their initial encounter with working with dissociation. Their description suggest that they each experience clients presenting different forms of dissociation from the somatic to structural dissociation and fugue impact of initial encounter with dissociation as often leaving them with a sense of bewilderment:

> "the first time….it was a lady who… came in and sat down and …she screamed and she sat sort of back in her chair and her eyes rolled back and she rocked and she curled up in sort of a foetal position on the chair and rocked and just cried and screamed...quite an alarming presentation." (Beth, lines 256-266).

> "there's a person that stands out that used to speak French sometimes in sessions and become very childlike. So she had, I guess…and thinking about, it, there's a lot about her life which seemed strange." (Gail, lines 327 – 331).

The description of initial encounters with such metaphors as “alarming”, “sad” “frightening”, “horrible” and “strange” indicate how disturbing dissociative presentations can be to therapists especially when they have no clue that that is what is going on for their clients. The implication of not knowing what is going on for the clients suggest that the effect initial and ongoing encounter with dissociation has on therapists can be traumatising:

> “Through experience…which is a frightening process in a way… Um, I think the way that dissociation presents itself, without the knowledge there, can be quite alarming, especially if you’re newly trained or not had that experience before.” (Beth, Lines 201 – 204).

The destabilising effect of encountering dissociation without having prior knowledge of it affects both novices and well experienced therapists, bringing about feelings of helplessness. A useful example is in the experience of Hannah, who is a senior psychologist who was expected by her team to pick complex cases:

> And I was thinking, ‘What the hell is going on?’ sort of thing. It was that extreme presentation really, that I had no idea how to deal with it. I had no idea how to think about it and yet I had these people in my office. And I had no one to give them to. This was about twelve years after qualifying.” (Hannah, lines 376 – 390).

The excerpt reflect the heightened sense of anxiety, Hannah must have felt on her initial encounter with an unusual clinical presentation. Her statement about not having anyone to give them to, suggests a sense of feeling trapped, deskilled and incompetent. She was the consultant

psychologist. Everyone referred complex cases to her and yet she did not understand what was going on with these cases.

For Diane, who was newly qualified when she had her initial encounter with dissociation, the sense of panic was not any different from Hannah's. What was different was that her default inclination was to call on more experienced others:

> "So I'm hearing this story in an assessment, and part of me is thinking, 'Well, he doesn't really mean that,' and then the other part's saying, 'Do I need to inform a GP or the doctor or the police? And where's my supervisor? And where's my boss?' (Diane, lines 582 – 586).

4.4.1.3 Expectation to be an expert

The pressure therapists feel in managing their experiences of being expected to be experts can be different depending on the length of post qualifying experience. There appears to be expectation that expertise comes with the length of post-qualifying working experience:

> "…another therapist was having trouble with her, sent her to me" (Anne 87 – 88).

Anne was able to take referrals from other therapists and feel confident in doing so because she has become an expert on working with dissociation. For some of the participants who have significant post-qualification

experience, the confidence is not always evident and the sense of expectation to know how to work with dissociation can bring on added pressure:

> "What stirred up…'Oh, right, okay. I need to read up on this so at least I've got something to say.' Because I think it was underpinned by fear. I'm thinking, 'My goodness, here am I fully fledged, and actually I don't know much about dissociation or dissociative disorder." (Diane, lines 309 – 314).

For Diane, who had sought the guidance of knowledgeable others, when she first encountered dissociation as a newly counselling psychologist, fifteen years after qualifying, she feels the pressure of the expectation to be an expert. Her statement "my goodness" suggests a sense of feeling inadequate. Given that she had earlier in the interview asserted that learning about dissociation in pre-qualifying training was not important and that what therapists need is to add to their knowledge and skills as needed, the sense of pressure to know, indicate conflict between different parts of her. It is possible that this pressure comes from not wanting to be judged by others.

Emma who is the most recently qualified of the participants, acknowledges an evolving understanding of dissociation, she knows her limitations and is open to holding these:

> "You don't always have to know everything and you don't have to get it right but you can be in that, like, safe in uncertainty… of being curious…" Emma, lines 401 – 405).

Emma gives a sense of being comfortable with not knowing much about dissociation. It is possible that her confidence comes from having appropriate training, supervision and having a team of likeminded practitioners around her. This confidence is also shown in her ability to be open to her clients. It sounds like nuggets she might have picked up from her trainers and supervisors:

> "…and perhaps also saying to people, 'Actually I'm at the start of this journey as well in the therapy space and will you come on this journey with me?' 'And I don't have all the answers." (Emma, lines 405 – 407).

4.4.1.4. Continuing development

The impetus to learn about dissociation often comes from needing to learn how to work with clients who present with different sell-states within sessions and from one session to the next. The quest for knowledge does not stop with initial training but appears to be career-long for many of the participants and sets them on a journey from novice to experts. For all participants, subscribing to to continuing development in learning about dissociation appear to alleviate some feelings of frustration or incompetence.

Some participants talk about how hearing more experienced colleagues talk about dissociation helped them to make sense of their clients' dissociative presentations. This spurred them on to learn more. It appeared that dissociation fits with a missing link in her understanding of what clients were presenting with:

> "…and I thought, 'Well this is really interesting. This is…you know, I'm hearing some echoes with what people are telling me in assessments and what you're telling saying. I think I need to learn a bit more about this.' (Emma, lines 252 – 256).

> "There was something pulling me. It just seemed like, 'Oh gosh, that just sounds like the sort of thing that might really help me with this client.' (Gail, lines 298 – 300).

The need for ongoing learning is depicted in Anne's report of accessing consultation for her work with a dissociative client and acquiring more formal training along the way:

> "…I got a lot of consultation. In the middle of working with her I learnt EMDR, which worked very well with her. (Anne, 117 – 120).

Participants recognised that without training, their work with dissociative clients maybe impossible. For example, Beth talked about needing to be agentic and seek training to enable her to work successfully with dissociative clients. She talks about *learning on your feet* which suggests

and urgency to acquiring knowledge, perhaps professional survival depends on it:

> "People may come in and you're not aware they're about to dissociate or that's there...So it is sort of learning on your feet to some extent … think the moment that happens – and it's happened to a few of us – we go and seek the training because… you need that knowledge. " (Beth, lines 221 – 225).

The need to learn more does not stop at initial access to acquiring knowledge about dissociation. Participants report the need for continuing development in their working knowledge of dissociation, thus suggesting that working with dissociation requires a commitment to ongoing engagement with training:

> "everything that I learnt has been out of school, and I have been a workshop junkie ever since. A training junkie. I keep learning. " (Anne, 716 – 718)

> "There's still a long way. I think in terms of experience of clients…I need more formal training." (Beth, lines 817 – 818).

Anne describing herself as a "training junkie" suggests an addiction to training and to keep learning. However, her narrative does not indicate a negative view of the need to keep on learning, rather it suggests a commitment to keep improving on her knowledge and skills in working with dissociation. This recognition for ongoing updating of knowledge and skills was also seen in Beth's assertion about still having "a long way to

go." Their perceptions suggest that with dissociation, there is no end to learning and the more one knows, the more one finds there is still a lot to know.

The journey from novice to expert has taken different trajectories for participants. Development from novice to expert is not about having significant years of post-qualifying experience. Whilst this does help in developing confidence, what participants talk about more is having support when they needed it, especially when they did not understand their clients' dissociative features. The more experienced therapists who are in leadership positions face added pressure of needing to be expert even when they are having initial contact with dissociative features in clients. Six of the participants talk about the importance of at least having some form of learning about dissociation in their pre-qualifying training, one participant offers the opinion that this is not necessary as you cannot learn everything to be learnt on training programmes. According to her what is important is to be able to learn continually from your own experiences after qualification. One participant offered the opinion that it is not what is learnt on the academic aspect of training that matters, but the richness of placement opportunities. This is what opens up rich experiences with clients and enables trainees to develop into confident therapists.

4.4.2. SUPERORDINATE THEME 2: SEARCH FOR KNOWLEDGE

Given the bewildering nature of clients' presentations, especially during initial encounter with dissociation, it is not surprising that participants were earnest in their **search for knowledge** of how to work with dissociation. Their search often started with appreciating the gaps in their knowledge and identifying their learning needs. Search for knowledge often starts with **learning from colleagues, accessing specialist supervision** and diverse **training opportunities**. It appears that access to support informs whether individual therapists continue to work with dissociation or avoid it.

4.4.2.1. Informal learning through talking to colleagues

For many of the participants, the immediacy of having experienced professional colleagues at hand, often mean that discussing their unusual clinical experience with these colleagues was imperative. The knowledge experienced colleagues share often inform the approach participants take to working with dissociation:

> "I was very lucky actually with that because I worked with a psychologist in CAMHS who had a big sort of training base from an attachment theory perspective. so I did training in terms of attachment and some inner child work there." (Beth, lines 464 – 468).

Emma's description of herself as "lucky" gives the impression that chance playing a big part in her being able to learn to work with dissociative features. She would not have been able to learn about attachment and

working with inner child if she had not worked in the worksetting and met the more experienced colleague. This sense-making of learning opportunity suggests that learning about working with dissociation is not integral to professional development but is situational.

4.4.2.2. Influence of supervision

Participants often use their agency to access appropriate specialist supervision. The ability to access this supervision appears to be informed by situated opportunity of work environment. The quality and approach of the supervisor has significant impact on how therapists develop their working knowledge of dissociation:

> "…and I got consultation from a woman… who's sort of a big name in this. And then my consultant for many years has been (Name withheld), who has written books about this and done many trainings…I have been in his groups and in his trainings on and off for a good part of my career". (Anne, 97 – 104).

From Folake, whose initial years of therapy work as in a multidisciplinary team setting up an innovative service, the importance of supervision was crucial. One gets a sense that the participant really thrived in her work environment, enjoying supervision from experienced and recognised names in the field. This was during her novice years and may suggest that such support at the beginning of one's career may influence the decision to continue working in challenging settings:

> "we were being supervised and monitored by (Name withheld), from the (Name withheld) and (Name withheld) and other eminent feminist psychotherapists, who had set up the Centre…" (Folake, lines 304 – 308).

Folake offers a narrative of her supervision pedigree. She acknowledges the influence of her supervisory relationship which she traces back to Freud:

> "the person who sent me to the (Name withheld) hospital, her name was (Name withheld) was (Name withheld). She was supervised by Anna Freud. Anna Freud was supervised by her father! Cha-ching! [laughing] (Folake, lines 571 – 577).

Given her critique of Freud, elsewhere in the interview, it is interesting that she still feels proud of her link to him. There is a sense of privilege in Folake's narrative of her supervision pedigree. The raised tempo of her voice as she said "Chas-ching!" and punching the air suggests a need for recognition that she has had the best influences in her career. Thus it appears that the form of supervision therapists access is not only about relevance but can also be about prestige.

4.4.2.3. Opportunities and challenges to accessing training:

After making the decision that they need to access training, for all the participants, the journey to developing working knowledge of dissociation is often dependent on their individual work settings. Work settings impact on their opportunity to access training, especially as there are financial implications and there is sometimes conflict between the therapist's' desire

to exercise agency in determining what training they need and the structural constraints on what the work setting is willing to offer.

> "So we sort of went on from there and managed to look up and find some training and it was a four-day training foundation in understanding dissociation… (Emma, lines 256 – 262).

Initial training on dissociation was experiential and she was able to take a case to training. There is an ethical implication here. Gail obtained client consent, thus having a collaborative approach with her client:

> "So we had to take a case with us. So, I remember talking to her about it and saying, 'This sounds like it might really help. It seems to apply to the kind of difficulties you're talking about. Do you mind if I talk about you on this course?'" (Gail, lines 180 – 185).

For some of the participants, access to training was a team venture. This is shown by their use of the preposition "we". For example, Diane says:

> "…we went on specific training about dissociation, which was very helpful. But until that point I didn't really know what it was, or how it manifested itself, or even maybe how to manage it." (Diane, lines 226 – 230).

There are also financial implications to accessing training. For some of the participants, there was little or no financial constraint, as their work settings earmarks budget for training:

> "But we are well supported… Every year. And our learning objectives are identified. And then there is a budget where if there's money in the budget it's allocated between us in terms of what training we want to do." (Beth, lines 924 – 931).

For participants who work in private practice and needing to pay for their own training, there are cost implications. Financial constraints can limit access to training. This may also apply to buying books, joining professional organisations or subscribing to journals:

> "…you're probably writing off the best part of £1,000 for two days training. So prohibitively expensive…It's well worth it. But you know, I can only do that maybe once a year." (Diane, lines 531 – 533).

Folake brought a useful dimension to the discourse on financial implications of accessing training. For her, accessing training opportunities can be limited by structural inequalities like class and ethnicity. This means that people of a certain class or background are unlikely to afford the astronomical cost of training:

> "There were very, very few places and you did it privately and you were white and you were middle-class and you had money. Otherwise you weren't doing it because you couldn't afford it." (Folake, lines 689 – 693).

Some of the participants talk about how the rise in the use of technology and multimedia has provided the opportunity for innovative approaches to accessing training opportunities. For example, accessing webinar training makes training more accessible and cost effective than face-to-face training:

> "They're also much cheaper than doing the body psychotherapy courses, which would be lovely to do. But, there's quite a lot of time commitment involved in that." (Gail, 368 – 378).

Participants not only learn through formal training and supervision, They talk about a range of multimedia including drama productions, reading books, doing online training, using workbooks and learning through videos which help them to learn more about how to work with dissociation:

> "Then I started gathering books about dissociation" (Gail,line 191).

Gail's narrative about gathering books suggests a thirst to learn all she could about dissociation. Similar enthusiasm was shown by Anne who talked about how a video helped her to grasp how babies can dissociate:

> "If you want to see any sad video, look up this still face videos. Watch a couple of these. from this guy named Tronick…And see what happens to a baby just when her mom starts disconnecting and then you think, 'She's a drug, she's a drug addict, she's depressed, she never responds.' You get dissociation then." (Anne, lines 365 – 361).

What was clear from all participants is the importance of supervision and training on developing working knowledge and skills in working with dissociation. Participants search for working knowledge of dissociation took different forms including formal training which can be face-to-face or through multimedia like webinars, books and videos. Access to training from multimedia appears to enable therapists ameliorate the effect of the high cost of training.

4.4.3. SUPERORDINATE THEME 3: WORKING WITH DISSOCIATION

The approach each participant uses in working with dissociation is often depicted in how they articulate their **definitions and theoretical perspectives**, their narrative on **Identifying Dissociation**, the impact **and influence of their worksetting** and the challenges of **working with multi-agency professionals.**

4.4.3.1. Definitions and theoretical perspectives on Dissociation:

Participants offer their own individual working definitions of dissociation. The definitions they give offer indications of the theoretical perspective that underpins their work. Definitions given are sometimes tentative. This perhaps shows the uncertainty that can be around what dissociation is. All participants proffer a relationship between the experience of traumatic experiences and the emergence of dissociation.

For Ceyone, it is important to differentiate the psychological and physical symptoms of dissociation:

> "I think dissociation for me is the inability of the individual's mind to be able to deal with a degree of emotion or trauma. So it is an alternative place that they go to, both mentally and sometimes physically, that then helps them to deal with the here and now at the time. if it obviously happens psychologically, we call it a dissociation. If it happens physically, we call it a conversion disorder." (Ceyone, lines 165 – 175).

The theoretical orientation in which Therapists are primarily trained, often informs their approach to understanding dissociation. Folake offers a psychodynamic informed explanation of individuals dissociating to avoid psychic pain. Thus dissociation can be seen as a offense mechanism:

> "the only way I can describe it is the psychic pain or the fear of the potential psychic pain. The fear of the potential psychic pain is so powerful, yeah? That they will have…they would rather have a completely other, yeah? Different experience, different set of things and create a whole different set of problems, rather than actually dealing with what is." (Folake, lines 441 – 448).

The insertion of "yeah?" suggests that Folake wanted confirmation that she was making sense. Prior to giving this explanation, she had been hesitant about giving a definition. One way of explaining Folake's hesitation is that dissociation was not a prevalent discourse at the period she was trained in and in theoretical orientation she trained in. She had

therefore had to translate what she knew as repression in psychodynamic paradigm to dissociation.

This meaning making of what dissociation is, is also given by Hannah who was only able to begin making sense of the processes of dissociation through a cognitive-behavioural paradigm.

> "I read all the psychoanalytic stuff about splitting and that got me even more confused and……and I didn't…because I was coming from a behavioural and a cognitive perspective , I just felt there was nothing there that I could hang my understanding of human beings on, really." (Hannah, lines 414 - 420).

Hannah talks about needing to be able to "hang" her understanding of human personality on a theoretical orientation she was familiar with. It therefore appears that having been extensively trained in CBT, she needed to understand how this approach conceptualises dissociation. She also talks about being "confused" by the psychodynamic explanation of splitting. This suggests that for therapist to begin to understand the notion of dissociation, it needs to start from the language of a theoretical orientation that they are already familiar with. This is another evidence of situated knowledge and calls into question the possibility that psychological therapists might be limiting treatment efficacy if they are only able to view clinical presentations from the lenses of their primary theoretical tradition. However, all participants in this study appear to

appreciate the importance of having a critical approach to the application of theories to their practice:

All participants have an evolution in the theoretical orientations they adhere to. From approaches learnt on pre-qualifying training to their ongoing professional developments. What appears clear is that they all propose an eclectic and integrative approach to working with dissociation. Participants have been exposed to several orientations in the course of their professional development. For example, Hannah having started off learning behavioural approaches, veered off to psychoanalytic. She describes herself as "rebelling" against and ultimately returning to Cognitive-Behavioural approaches:

> "I started off as a Jungian psychoanalyst… I wasn't trained as one but I studied in …University, which had a very strong behavioural influence and I rebelled against that and decided to have a slightly psychoanalytical bent…When I moved into learning disability, I found that psychoanalysis wasn't much use to me so I became very behavioural then. (Hannah, lines 172 – 178).

For Hannah, there is the pull between striving to be agentic and owning one's own path to professional development and the power relations between self and one's supervisor:

> "that's where I kind of…I continued being determinedly psychoanalytic but I gradually changed under the influence of my supervisor." (Hannah, lines 196 – 198).

Having been stirred towards CBT by her supervisor, Hannah still sought to have her own perspective on the utility of CBT in working with dissociation. She explored an integrative cognitive-behavioural therapy approach to working with dissociation. Transitioning from initial behavioural approach to second wave cbt to third wave CBT was the result of therapist agency and willingness to learn what was not taught or available to be taught during initial training, she used a case example to explain how she uses CBT:

> "So he might also characterise these two different aspects of himself. You know, the angry self, the… alcoholic self! [laughing] Well probably the angry and the alcoholic self would be the same. Or they might not be. But they might be. Um. This is quite similar to Jeff Young's work where…you know, he's a schema guy, but he's also written about modes. Now these are different modes, I'm afraid, than Beck's modes. They're more like clusters. They're more like self states or mini-personalities and he would say you've got an angry protector. You've got a detached protector, which might go and get drunk. 'Well nobody cares about me so okay, I can go and get drunk,' you know? An angry self who just lashes out the moment he perceives being attacked. And a kind and caring self, which he might call the healthy self. And so Jeff Young's work is all about how you build a healthy self…And actually, he would say you fight against the other selves, whereas I would say you validate the other selves." (Hannah, lines 1022 – 1041).

Looking at Hannah's extensive description of Young's schema therapy, it appears similar to other parts psychology approaches like ego state therapy, inner child work and Richard Schiwarz's internal family systems.

These have been around long before Young's schema therapy. What seems apparent here is that these ideas are not original to Jeff Young and have been borrowed from other traditions and incorporated into CBT framework, thus suggesting an eclectic/integrative approach to understanding dissociation.

The sense of integrative approach to working with dissociation is a common feature of all participants' discourse. For some like, Hannah, the integration is implicit. For others, there is a more explicit narrative of drawing from diverse theoretical traditions:

> "I take the parts I think work and leave the rest. What I say is I don't do any therapy right. I do what works for the client in front of me." (Anne, lines 415 – 417).

Folake offers a passionate discourse of her stance. This is particularly useful as she is the only participant of African/African Caribbean background. She talked about integrating an African-centred perspective to her interventions. She offered a critique of Freud's theory by opining that it is limited by what she sees as Freud's inability or unwillingness to look at the spiritual aspect of the human psyche:

> "psychology originally was the study of spirit . It wasn't behaviour. It got termed by the Europeans into behaviour. The Europeans are very, very afraid, couldn't touch, feel and whatever . So what Freud did was take the whole notion of the unconscious which is about spirit. And if you look at Freud…if you look at Freud's…if you look at the Freud

> Museum, for example, and you look at his desk, he has more Egyptian artefacts than anything that you could imagine." (Folake, lines 79 – 89).

4.4.3.2. Identifying Dissociation

The journey to knowing about dissociation takes similar trajectory for many of the participants. Often, what makes them have a realisation that the phenomenon they are observing in their clients is dissociation is situational, being based on their work setting, supervision and evolving training experiences. Participants acknowledge that it was possible that they had encountered clients with similar clinical presentations as the first client they recognised as being dissociative, without conceptualising it as such, as they had no knowledge of dissociation. An example is Anne:

> "I'd been in practice maybe three years or four years… and then I got this client. And I may have seen other people but I didn't know…But now I know! I can…I can spot dissociation now." (Anne, Lines 192 – 197).

Anne's assertion that "I can spot it now" indicate a journey into discovery. Her narrative is similar to that given by other participants. They all acknowledged that they had probably seen dissociative clients but had not had the framework to conceptualise the clinical presentations as dissociation.

An interesting account was given by Gail who worked with a dissociative client for 6 years before realising that her client's clinical presentation was dissociation. For her, the evolution of her working knowledge of dissociation started from gleaning of popular culture and seeing examples of these in client presentation:

> "I'd been casting around for all sorts of things and I think probably I thought about multiple personality disorder but I didn't really know anything about that. I had come across a few people in the past with…who I thought, 'That sounds a bit like what they used to call multiple personality disorder.' And like many people, I suppose, at that stage, my understanding was very rare and I'd hardly ever met anyone like that. There's been a couple of films made. A couple of classic films about dissociation; dissociative personalities. So, I kind of thought, 'Well, this does sound a bit like that, but it probably isn't." (Gail, lines 254 – 267).

Participants also acknowledged the situated knowledge and therapist agency to working with dissociation. The impact of training on therapists' understanding of dissociation is that once the knowledge is acquired, the presence of dissociation in clinical populations becomes obvious. What was hidden becomes open and glaring:

> "I think what sums it up about dissociation, is that you do start spotting it all over the place. Who knows how many people I've seen in the previous years, but just not had a framework to… understand." (Gail, lines 518 – 527).

Sometimes clients would have been seen by several members of the multidisciplinary team. This confirms what the literature says about dissociative clients remaining in services for a considerable length of time:

> "…other people who'd worked with her, some of them I remember quite critical saying, 'Sometimes she can cope very well and other times she just says, you know, she can't do anything at all.' We're trying to make sense of this with her, and how she can be so different. (Gail, lines 216 – 222).

4.4.3.3. Influence of Work setting:

Participants talk about the influence of their worksettings in helping them to develop working knowledge of dissociation. Through the interaction with colleagues they began to conceptualise and recognise dissociation in clients they would not have in previous work settings:

> "I suppose it was when I started in this job at the CMHT. And, you know, people sort of said, 'Oh maybe they're dissociative or maybe they've got dissociation,' and I didn't have any idea about what that is but I don't really know about it, and we were getting a few more people referred where we were sort of assessing and almost kind of thinking, 'We don't know what's going on with this person.' And people were presenting with memory loss… and blanks in time." (Emma, lines 232 – 241).

Knowledge of dissociation depends on time and place. Dissociation can be easier to identify in some clinical populations than others for, example, clients with history of abuse. However, in LD populations, for example, communication difficulties can present barrier to identifying dissociative features:

> "I saw it in learning disability, but I didn't recognise it… because people weren't able to verbalise their internal world so easily. And then when I moved into the mental health work, again I got people entrenched and treatment-resistant and a lot of them of course turned out to have massive abuse histories." (Hannah, lines 333 - 335).

Some work environments allow for therapist's creativity in exploring new ways of working with clients:

> "I began to play with working with people who had a lot of mental health experiences in those processes, in different kinds of ways, you know?" (Folake, lines 244 – 247).

4.4.3.4. Challenges of Multi-agency working:

Many of the narratives given by participants suggest that when possible, working with dissociation is often done in collaboration with other professionals in the multidisciplinary team and there is often need to collaborate with other agencies. This can pose a challenge in that not all multi-agency professionals share a mutual understanding of dissociation:

> "he was found homeless and wandering when we first picked him up, and they brought him on a police section." (Ceyone, Lines 540 – 541)

Ceyone's use of the use of the pronoun "we" when discussing the case of a man brought to inpatient unit suggest a collaborative approach to intervention. Her use of phrase "picked him up" is intriguing in that it

suggests a person lost. This along with the fact that he was sectioned whilst homeless and wandering connotes a sense of dissociation from the world and everyday life experiences.

Collaboration within teams and with multi-agency professionals is not always easy. Participants talk about having to convince multi-agency colleagues that there is a function to clients'' apparent manipulative behaviour. It is not surprising that the participants express feelings of frustration, especially when whole systems around a client do not have understanding of what is going on for clients:

> I did what I could do, but sometimes I feel frustrated, because I'm only part of a chain of people who need to be acting together cohesively, and sometimes that doesn't happen . And we know about this politically with baby P, and Victoria Climbié… (Diane, lines 662 – 667).

Participants talk about the struggle to be taken seriously by powerful others and how their own professional credibility and integrity is sometimes at stake because their professional opinions on dissociative features in clients are not believed:

> I've never had any desire to feel special in that way. In fact, I'd rather not. It's like people often say people make up sexual abuse to feel special. Or they make up multiple personality disorder to feel special. I always say, 'Well it's a damned shame if you've got such a sad life that you have to make stuff like that up.' (Hannah, Lines 1863-1869).

Hannah appeared aggrieved by the constant need to prove her integrity. This feeling of being doubted by others appears to make those who work with clients who dissociate to be guilty by association. If the clients are considered to be making up dissociation and manipulative, it seems that those who take their presentation seriously and work with them are also considered to be untrustworthy.

This challenge of working with mistrustful professionals appears to cross across continents. For example, Anne who is the only non-UK based participant wanted to know how the dissociative phenomenon is viewed in the UK:

> "How is it in the UK? Here there are many psychiatrists and, like, hospitals that do not believe in dissociation. They just think everybody's borderline and if they have more cognitive therapy they'll be okay" (Anne, Lines 316 – 320).

Emma reflects, that perhaps multiagency professionals "dissociate form dissociation":

> "we've cut off from dissociation and trauma because it's painful to think about. In a similar way to the way in which, you know, sort of sexual abuse has been ignored for a large proportion of time because it was painful to think about." (Emma, lines 974 – 982).

Emma reflects, that perhaps multiagency professionals "dissociate form dissociation". This suggests a move away from an unpleasant experience.

People who experience dissociation seek distance from their experiences. Professionals also seek to move away from helping them explore these. This can lead to entrenched clinical presentation. Perhaps for professionals who dissociate from dissociation, it is about self preservation.

4.4.4. SUPERORDINATE THEME 4: USE OF SELF

Participants' discourse suggests self-awareness and use of this to see a **common humanity** between their clients' presentation and their own stories. Perhaps as a result of this, they are able to, albeit to different degrees **normalise dissociation**. The extent to which each participant is able to share power with clients and empower them to be agentic, inform the **role of the client and therapist in the therapeutic relationship**. All participants stress the importance of **self-care** in working with dissociation.

4.4.4.1 Common humanity

Some participants were able to draw on their own personal experiences to inform their understanding of what may be going on with their clients who dissociate:

> "…personally how did I cope when my mom died last year?...it was only maybe three or four months after she passed away that I then felt all the sadness. So possibly for me I was going

> through some type of dissociation after mom died and I think this happens to lots of people." (Diane, lines 143; 159 - 163).

Diane used her experience of bereavement to construct an appreciation of what may be going on for her dissociative clients. Whilst tentative in her description of this as dissociation, she drew on a common humanity of distancing one's self from painful experiences.

Folake relates her client's experiences with her own experiences as a child. Infants do what they need to do to survive by attuning to their mothers. Participant talks about how the need to attune to her mother's need enabled her to hone in her intuitive ability which prepared her for a career as a psychotherapist. Her narrative could be seen as parentification. However, her narrative suggests that there are positive sides to parentification. Children do have agency and sometimes they may use their agency to dissociate in order to survive traumatic experiences.

> I am one of my mother's favourite children. She brought me close to her … she was very depressed and there was something about me that kept her… …alive. And she said, 'You saved my life. You kept me alive. ' And I was incredibly engaging, and I brought her out of it, you know what I mean ? If you ever hear my mother talk about raising children, I am the only one she remembers and will give examples about. I was, 'Come on Mummy, come on Mummy, come on Mummy, come on Mummy!' Yeah? And it was like I dragged her out of the depression, and I think what I learnt in that process is how to intuit what was going on with people. From a very early age. That's why I'm a good psychotherapist. (Lines 580 - 602)

Folake had earlier talked glowingly about her own experience of personal therapy as a trainee. It is not surprising that she sees having significant personal therapy as being crucial to developing as a psychological therapist as in her words therapists and clients are all broken and twisted and without exploring one's one brokenness, it is impossible to truly help another. You cannot take others where you do not want to go:

> "The experience of personal therapy, the experience of understanding what makes you tick and why you tick like you tick takes you to then be able to understand at a meaningful level what makes other people tick. Now they may be broken and twisted and whatever in different places, the way you were broken and twisted… you know what? We're all broken and twisted." (Folake, lines 1170 – 1177).

The awareness of consideration of psychological therapy and its form in working with dissociative clients appears to be informed by the time and place in which the therapist is practising. For example, Ceyone suggests that:

> "I'm probably a traditionalist because I grew up in India, and psychological fields are not very much attended to, especially in my day and age. In the late 1980s, or even the 1970s, this was not something that had lots of coverage in India." (Ceyone, lines 114 – 119).

4.4.4.2. Normalising dissociation:

Participants report that client's dissociative behaviour can be seen by some multi-disciplinary and multi-agency professionals as manipulative. Like all other human behaviour, understanding the function of dissociation

may enable professionals develop a more empathic relationship with cleints with the features. Participants talk about taking on a relationsional approach to their work and this helps them to understand more about why and how dissociation affects individual clients.

> "I think dissociation, it hasn't always got negative connotations; it actually can be quite useful." (Diane, lines 138 – 139).

Diane's positon on drawing the positive from dissociation echoes the approach many of the participants take to working with dissociation. Understanding the function is the key to supporting clients to relate more positively with what they are dissociating from. The clinical assumption appear to be that if an individual is experiencing traumatic experiences, the effect might be too disturbing for them to manage. Dissociating is one way to manage the trauma. Working with dissociative clients therefore requires an understanding the functional role of dissociation, stabilising thoses affected and working through the trauma which necessitated the dissociation and then integrating self-states.

The sense of normalising dissociation is also seen in participants' attitude to diagnoses. Whilst all are aware of assessment and diagnostic measures, most of the participants talk about taking a humanistic approach to assessing:

> I don't see myself as someone who's involved in the diagnosis, really. I just go from how somebody understands themselves. (Gail, lines 706 – 708).

Participants' view also relate to the utility of assessment and diagnostic measures. Participants' attitude to the use of assessment and diagnostic measures varies. Whilst some acknowledged that as novices, they had used measures, they report having less need to use formal diagnostic tools as they developed their expertise:

> "I don't at this point but I have used Colin Ross's tools. I've used the DES. ..Um, but no, I don't any longer because I have been working with dissociative people for over thirty years. ..And so I kind of know what I'm doing! [laughing] (Anne, Lines 260 – 265).

Anne's assertion suggests that she has an expert knowledge of what is going on for her clients. This is in contrast to some participants who use psychological measures to aid discussion with clients.

4.4.4.3. Power Relations in Therapy: Role of therapist and client in therapy

Participants report a need to work collaboratively with clients. The extent to which participants use power together with their clients and allow clients to use their agency is apparent through their use of language. For example, Anne and Ceyone talking about "fixing":

> "I have plans for knowing if they're DID. You know? You fix it." (Anne, lines 333).

> "It's very interesting. If you have something which is together but is broken, you don't put it right just like that. You have to first of all, understand how it's together, despite being broken, then figure out how you're going to remedy it to fix the broken part and still keep the strength of the patient." (Ceyone, lines 375 – 379).

The use of the word fixing connotes a medical model of working with dissociation. This is in contrast to the client-centred perspective participants have been espousing. This suggests a balance of client-centred and therapist-led approach to intervention. It appears that the extents to which therapist empower clients to be self-directing is informed by the level of dissociation. With highly dissociative clients, it might be useful for the therapist to act like a parent and be directive until such a time clients can take on more power in the therapeutic relationship. Ceyone stresses this by saying:

> "I don't go in there with the imagination that I have the answer. I don't have the answer, because everybody's answer is different, and many, many people might choose to remain dissociated, but I want them to be aware that while they are choosing that as an option, there are aspects of their other reality which will get ignored, or are not being dealt with." (Ceyone, lines 396 – 403).

The importance of the therapeutic relationship and is a running theme for many of the participants. They stress the importance of openness and

curiosity and its priority over diagnosis. Collaboration with clients is achieved through reflection on what works and what does not work in their clinical work. This open engagement with clients can be validating and enable helpful intervention. Modifying the application of approaches to fit in with what clients are ready or able to do appear to enable shifts in clients.

4.4.4.4. Self Care:

All participants consider self-care as key to being able to continue working with dissociative clients. This is more so because in the main, participants consider working with dissociative clients as challenging. All participants stressed the importance of appropriate supervision to their continuing engagement with working with dissociative clients. Supervision styles include peer and clinical supervision:

> "Supervision's really key to not be carrying that stuff, is to…to discuss it and get support and…and think about how things affect you … and what impact hearing those things has, is really helpful. (Emma, lines 1000 – 1005).

Participants talk about maintaining boundaries in terms of their caseload. Some participants, especially those who work in private practice are able to be more agentic about what types of cases they take on. For those who work in organisations, this opportunity may not always be possible:

> "…it is about knowing where to stop as well, I think. Personally. Knowing how much you can do and how much…I

> think you might be able to do much more, but I guess we all do what we can and try and keep ourselves sane." (Gail, lines 969 – 974).

Anne offers an interesting perspective on how the structural inequalities that permeates society can extend to the role of the psychological therapist. She talked about how her ethnicity privileges her and affords her opportunity to choose:

> "as a privileged, white person who's been in practice a long time, I can be in private practice and choose." (Anne, lines 748 - 750).

Anne's assertion of having white privilege suggests a sense of self-awareness and at the same time reflects that even amongst therapists, there is no level playing field, as therapists from diverse communities may not have the freedom to choose. It is useful reflect on the responsibility of therapist to social justice both in the multi-professional disciplines and also how structural inequalities impact on clients.

Participants also talked about caring for themselves outside of work setting. For all of them, engaging in non-work related activities is a form of destressing. In the words of Anne:

> "…this is what my consultant, says. If you are working with this population, you must have something else compelling in your life that is not work-related." (Anne, lines 682 - 684).

Anne's received wisdom form her supervisor on how to survive and thrive whilst working with dissociative clients is another example of how supervisors influence therapists' approach to working with disscoaition. The need to find other compelling activities to engage in is a common theme amongst all participants. They identified a wide range of activities they engage in, to care for themselves. These include going on regular vacations, engaging in physical exercises, going to the theatre, watching comedies.

Apart from leisure activities, participants also talked about the use of additional professional skills set that do not involve directly engaging in therapy with clients. These skills set include offering supervision, consultation and training:

> "So being able to give by speaking… being able to give by writing uses different parts of me." (Anne, lines 706 - 709).

Many of the participants talked about the importance of having access to their own personal therapy. This may be self-administered therapy or therapy from another:

> "I will get EMDR if I have any kind of traumatic reaction after a few days, you know? I'll self-administer or I'll go to a colleague and I'll say, 'I need to get this person out of my body.' And I want to be able to think about them, to help them, to be there for them, but not get traumatised by the story." (Anne, lines 713 - 719).

The importance of self-care is one that is stressed by all participants who all opined that without it, their ability to continue working with dissociative clients would be limited. Perhaps, therapists who work with dissociation need to dissociate from the narrative in order to recoup and re-energise to work with what they all consider to be a challenging clinical presentation. Thus, like their clients who may dissociate to be able to cope with traumatic experiences, therapists who work with this clinical population also need to take a step back in order to be able to continue working with them.

4.4.5 Summary of findings and Analysis

The analysis has offered a double hermeneutics of participants' data, offering a description and analysis of the subjective lived experiences of psychological therapists who have working experience of dissociation. Overall, the exploration of the interview data revealed four super-ordinate themes, each with four subordinate themes. There are links between these themes and they are not mutually exclusive.

Most of the participants expressed a deficit in their preparedness to work with dissociative clients as a result of not having learnt about dissociation in their pre-qualifying training. Those who had at least some knowledge found that they were prepared to seek support when they encountered the feature in their clients. However, not all participants felt it was crucial part

of pre-qualifying training. In the word of one participant, it is clinical experience that builds knowledge, not necessarily classroom learning.

For all participants, initial encounter of dissociative features in clients can be quite disturbing, especially for those who have no prior knowledge of dissociation. What seems to enable therapists to continue working with dissociative clients is the level of support they are able to access from their teams and supervisors.

Having identified, dissociation all participants were agentic in seeking knowledge on how to work with the presentation. The level of support they get in accessing training was dependent on their worksettings with some having their training paid for and others having to fund their training, especially those in private practice.

Participants' working definition of dissociation appears to be influenced by the theoretical orientation they adhere to. However, it was clear that there is implicit and explicit adherence to eclectic and integrative approach to their interventions. This is perhaps because all participants have accessed training in diverse modalities. Furthermore participants offered critical perspectives on theoretical orientations, perhaps reflecting their many years of experience.

Finally participants used their own knowledge of themselves, their family, cultural experiences and values to underpin how they work with dissociative clients. They all gave narratives about the draining and traumatising nature of working with clients with dissociative presentations. Apart from the complexities of working with dissociative features, participants also talk about the challenges of working with multi-disciplinary and multi-agency colleagues who do not share similar understanding and acceptance that dissociation can be a legitimate clinical presentation. They therefore have different ways of taking care of themselves

4.5. Discussion

The aim of the current study was to explore how psychological therapists develop their working knowledge of dissociation and how they assess and treat clients with dissociative features. Whilst existing literature on dissociation is quite robust, there is paucity of studies on the journey psychological therapists take to having a working knowledge of dissociation, the influences on them and what has enabled them to continue working with the complex and often challenging presentation. This is a significant gap in knowledge. The current study aims to bridge this gap in knowledge as it has the potential impact of contributing to psychological therapists have a more critical perspective on their use of theories and models of working with dissociation, offer suggestions on

what is important in pre and post-qualifying training programmes and inform review of policies and official guidelines on working with clinical populations. This section also highlight suggestions for further research based on the findings of the current study.

In order to explore the research topic, three research questions were posed. The first research question was *"What theoretical framework underpins therapists' understanding of Dissociative Features?" It was important to explore the theoretical framework that underpins the approach that therapists take to working with dissociation.* Stokoe (2016) found that there are several approaches to understanding dissociation, whilst these may sometimes converge, they can also be contradictory. For example, the trauma model posits that dissociation is the result of complex trauma which often have their roots in early childhood. Lyne (2014) on the other hand offer an iatrogenic perspective which suggests that dissociation is due to fantasy-proneness. With such divergent views, it appears imperative to understand what perspective informs the approach individual therapist take and the influences on their journey to working with dissociation.

All eight participants share the view that dissociation is often the result of trauma and/or attachment relationships in early childhood. Their narratives also indicate that they are informed by structural theory of dissociation (Van der Hart, Nijenhuis & Solomon, 2010). None of the

participants propose a fantasy model of dissociation (Lynn, 2014). Rather many of the participants express frustration at the challenges they encounter in working with multi-agency colleagues who believe that dissociation is co-created in therapy sessions by therapist and their clients.

The second question guiding the study was *"How do therapists assess and treat dissociation?"* The particular approach to working with the different self-states in clients differ. For example, one participant use cognitive-behavioural approach, some use ego state theory, working with healing the inner child and other wounded parts. One participant works from a psychodynamic and African-centred perspective. What was clear in participants' responses is that they are all able to identify possible signs of dissociation in clients. This may be through the use of psychological measures or through interview. The wider literature (Steinberg, 2000; Brand, 2012) suggests that the most commonly used psychological measure for exploring the possible presence of dissociation in a client is the dissociative experience scale (DES).

Five of the participants have used this tool, one knows about it but has not used it and two have not used it before. Amongst the participants who have used the DES, there was the caution that it only offers an indication and is not diagnostic. This is in line with existing literature (Ross, Schroeder & Ness, 2013). Some of the participants also talk about other

tools, for example the Wessex dissociative Scale (WDS (Kennedy, 2013) and the Structural Dissociative Questionnaire (SDQ) (Steinberg, 2000). The extent to which participants use psychological tools to measure dissociation in clients can sometimes be about their confidence in identifying dissociation without recourse to using tools. Two of the most experienced participants report that they only use tools for funding purposes as they need to have baseline and outcome measures to demonstrate to commissioners that their intervention is successful.

The third research question was *"How do therapists derive evidence that their approach works?"* Participants report that they found that having working knowledge of dissociation had positive impact on the outcome of interventions with clients. For example, some found that with clients who have been in their service for a considerable length of time, there was a shift after they started acknowledging their dissociative experiences and working with this in therapy. They report a relationship between dissociation and many other client presentations like eating disorders, depression, anxiety and psychosis.

With protracted client presentations, participants found that when they acknowledge the role of dissociation and work with these, there is a shift towards integration of self-states in clients. Furthermore, participants report that the knowledge of dissociation often enabled clients to understand why they appear to have shifts in lived experience. Thus,

dissociation provides a language through which clients and therapists can normalise an unusual presentation. These anecdotal clinical evidences provide therapists with evidence that working with dissociative states lead to more positive outcomes in clients. Participants describe dissociation as a process and there is no simple “end product” to intervention. The more integrated clients feel, the more indication there is that they are getting less dissociated and the more they will be able to engage more in their environment. The wider literature indicates that there is no official guideline on how to work with dissociative features (Stokoe, 2016). The ISSTD provides guideline on working with dissociation for adults, children and adolescents. Stokoe (2016) suggest that it would be useful for there to be NICE guidelines on what works in working with dissociation.

4.5.1. Research findings in relation to existing literature

Overall, in exploring the research questions, four superordinate themes, each with subordinate themes were identified. The discussion section will now offer a synthesis of how these findings support or deviate from existing studies and how the current study has contributed to knowledge of how therapists develop their competence in working with dissociation.

Superordinate theme 1: Novice to expert: The findings offer an understanding of the extent to which participants perceived their pre-qualification training prepared them to work with dissociative features in their clients. The extent to which participants had any form of training in

dissociation is dependent on their professional disciplines and the situated knowledge of where and when they trained. Some of the participants talked about the use of personal agencies by their cohort to ask for seminars on dissociation. This afforded them the opportunity to have basic knowledge of working with dissociation. It was surprising that the one participant whoa talked about significant training in dissociation during her training was the only psychiatrist in the study.

Participants talked about the impact of initial encounter with dissociative features in clients, the pressure they sometimes felt to be expert in working with dissociation even when they did not understand the phenomenon they were witnessing in clients and how this led to their need to learn more about working with dissociation. Buckman and Barker (2010), in a study of the influences on the theoretical preferences of trainee clinical psychologists found that there are many influences. These include a combination of individual beliefs and worldview, personality, training experience and evidence base for specific approaches. With the exposure to dissociation during pre-qualification training being diverse, what was apparent was that those therapists who had at least some knowledge of dissociation were more prepared when they saw these features in their clients.

When there is no knowledge of dissociation, initial encounter can be difficult and disabling for therapists, even after many years of post-

qualifying experience. Williams, Judge, Hill and Hoffman (1997) explored the influence of training on moderating the level of anxiety and self-efficacy of trainee therapists. They found that evolution of training led to changes in trainees' anxiety, self-efficacy, ability to manage countertransference issues and enhance therapeutic skills. More recently, Skovholt and Ronnestad (2003) opined that the journey of the novice can be challenging. They found that the major cause of stress for the novice therapist is the lack of clarity about new experiences. This can lead to anxiety about intervention, scrutiny from others and limited sense of self-efficacy in relations to role which may lead to need to place more pressure on self. They suggest that having positive mentors can help ameliorate the adverse effect of the weight of expectation from self and others. In the current study, the participants are well experienced therapists, some of whom find themselves in a novice position when they encounter dissociative features in clients. The weight of expectation to know how to work with this presentation appear to be challenging to sense of expertise and the willingness to be comfortable with being a novice and readiness to learn about dissociation is what marks out therapists in their subsequent journey from novice to expertise.

Participants talked about having a sense of agency to acquire knowledge of working with dissociation. This led to them accessing training and supervision to help them work with dissociative features and with this, they gained momentum and confidence in their interventions. With the

understanding of dissociation, they were able to have deeper level of insight into clients' presentation and have more positive outcome to interventions.

Superordinate theme 2: Search for knowledge: The therapists in the current study described how they needed to search for knowledge on how to work with dissociation. This search for knowledge was both informal, through discussion with colleagues and readings and more formally through accessing supervision and training. This finding supports Orlinsky, Botermans and Ronnestad's (2001) findings on the influence of peer learning and supervision on therapist development. Whilst all participants accessed formal training in working with dissociation, the first and most influential source of learning opportunity comes from working alongside therapists who had more experience of working with dissociation. Where this is not available, it appears that participants are discouraged from working with the complex presentation.

Superordinate theme 3: Working with dissociation: In line with existing literature (Farber, 2008; Kluft, 2012; Miga, Korslund & Linehan, 2015), participants report an eclectic and integrative application of theories and models of dissociation in their practice Stokoe (2014) argue that it is important for psychological therapists to be appraised of the theoretical underpinning of the approach they take to working with dissociation. Participants in the current study offer diverse approaches to working with

dissociation. In the main it would appear that the structural theory of dissociation (Nijenhuis, vanderHart & Steele, 2004; Nijenhuis & van der hart, 2011), trauma model (Ross, Schroeder & Ness, 2013) and ego state theories (Schwartz, 1995; Kluft, 2012) are the most commonly used approaches. Two of the participants have a psychodynamic understanding of dissociation, seeing it as a defense mechanism against unwanted experiences.

An interesting aspect of this finding is that participants' particular model of similar theoretical perspectives are distinct. For example, one participant who uses a cognitive-behavioural approach was critical of EMDR whilst another who finds EMDR useful was critical of CBT. The current study supports Stokoe's (2014) which found that many of the participants in her study use a staged approach to working with dissociation. However, there are differences in models used with some participants using the trauma model and some using the dialectical behavioural therapy approach. What is clear from the current study is that the influences on participants were mainly based on the situated knowledge of their worksettings, supervisors' theoretical orientations.

The wider literature on how individuals develop proficiency indicate a range of learning theories which whilst not specifically about learning to work with dissociation is applicable to how learning takes place and is therefore transferable to understanding how psychological therapists

develop their working knowledge of dissociation. These learning theories include Bandura's social cognitive theory, Vygosky's Socio-cultural Theory, Piaget's Cognitive development theory and Kolb's experiential learning theory amongst others.

Holzman (2014), in exploring the value of socio-cultural theory, propose that social interaction plays a significant role in learning. According to him, for learning to take place, there is first the need for interaction with others, what is learnt from these interactions would then need to be integrated into the individual's mental structure. Secondly, is the idea that a zone of proximal development is essential for the enhancement of learning. According to Bruner (1999), the potential for optimal learning experience is informed by a combination of the learner's cognitive ability to acquire required knowledge and the availability of support and social interaction to aid learning. Thus learning experience is enhanced through the support given by a more experienced other who provides support as the learner engages in the learning process. Holzman (2014) propose that the world of psychological therapy can draw from sociocultural theory to inform interventions. The responses which participants in the present study gave, suggests that without being explicitly stated, they and their mentors, colleagues, supervisors, and trainers have drawn from learning theories to develop working knowledge of dissociation. This can be seen through learning and working alongside more experienced colleagues and relying on guidance from diagnostic manuals until gaining confidence in identifying dissociation.

Participants offer narratives that suggest a significant influence of their cultural background on their practice. Two of the participants are from ethnic minority groups – Indian and Black African Caribbean. The extent to which they draw from their cultural background to inform their case conceptualisation is informed by the extent to which they actively engage in using the philosophical tradition of their culture of origin to inform their worldview. One participant talked about integrating an Africentric perspective to the psychodynamic orientation she trained in. This makes her see dissociation and other mental health difficulties as transpersonal experiences. The other participant was influenced to appreciate the psychological model of mental health difficulties when she came to train in the UK. This was a move from the medical model she was trained in in India. The finding here suggests that cultural influences cannot be perceived in a lineal way and is informed not only by place but also period of training.

Whilst there have been no specific studies on the impact therapists' cultural background has on their approach to working with dissociation, Several studies have shown that dissociation expresses itself in different ways from one culture to another (Dunn & Dunn, 1998; De Maynard, 2009; Rhoades, 2006). One participant in this study emphasises the role of culture in clients' presentation and how she works with cultural nuances. The opportunity to work in a culturally competent manner with women of African-Caribbean origin whilst suggesting she was agentic, was equally

made possible by the structure of her worksetting which was able to fund and facilitate a culturally informed approach to working with women of Black African and Black African Caribbean origin.

Participants discussed a range of factors that limits therapists'' capacity to identifying dissociation in their clients. These barriers include structural inequalities that militate against some clinical population. These can be disabilities, ethnicity, age, gender, sexuality or any other factor that disadvantages individuals because they are not members of the dominant culture. Two of the participants talked about only developing working knowledge of dissociation when they changed jobs and moved to working in settings where the role of dissociation in mental health presentation was recognised and worked with. They were then able to reflect that they had observed similar confounding presentations in their previous worksettings – one worked in a Child and Adolescent mental health setting and the other with a learning disabilities population. Consistent with the findings of the current study, Stokoe's (2014) participants also identified the challenges clients have in accessing appropriate services. Perhaps, more studies would be useful in helping to work with dissociation in disadvantaged population. For example learning disabled clients. Perhaps, non-verbal approaches to assessing dissociation would be useful.

Many of the participants talked about the impact of not knowing about dissociation on their work with clients. They offer that many of the clients

have revolved through several members of their multi-disciplinary teams, with different labels and are often seen as manipulative. Previous studies corroborate this finding and suggest that clients who present to mental health services are often treated for several years as clinicians are unaware of them dissociating. In the current study, participants found that with the knowledge of dissociation comes the respect for the different self-states clients present with and skill to work with these, thus removing the stigma and challenges of multi-disciplinary colleagues contending with one another over diagnostic labels and different perception of clients.

Superordinate theme 4: Use of self: Participants' discourse indicated approaches that go beyond what they have learnt from training and supervision to their sense of agency in drawing from their own lived experience to inform their approach to working with dissociation. All participants normalised dissociation with two drawing from their own personal experiences, one of dissociating from the sense of loss of a parent in order to be able to function in daily living and the other drew from her experience of having a depressed mother to have an appreciation of the function of dissociation in their clients' presentations. This sense of common humanity shared by therapist and client is a central part of many therapeutic approaches, for example, acceptance and commitment therapy, humanistic paradigm where the concept of congruence is one of the pivotal aspects of the process of therapy and psychodynamic

approaches where the concept of the therapeutic relationship is seen as crucial for positive outcomes in therapy interventions.

The power relationship between therapist and clients is one area of therapy intervention that has been widely written about (Tutton & Martin, 2009). In the current study, all participants in their narratives offered insights into the degree to which they shared power together with their clients in the various processes of assessment, formulation and intervention.

Participants talk about the challenges of working with dissociation and how they take steps to ensure their continuing wellbeing. This finding corroborates Collins and Long (2003) finding that Health-care workers who work with trauma victims are subject to significant stress and are vulnerable to secondary traumatic stress. Perhaps, with dissociation not only being a challenging presentation but also contentious, the stress therapists experience is elevated. Participants report that they would not have been able to continuing working with dissociation.

Participants utilise a range of self-care strategies including engaging in physical activities, developing functioning relationships outside of working, taking on activities that are non-work related and engaging in personal therapy. These findings support Norcross' (2005) finding that psychological therapists who have their own personal therapy are more

attuned to their own, as well as their clients' emotional needs and they are more relational and develop greater level of professional capability overtime.

Only one participant did not mention accessing therapy as a self-care strategy. However she engages in physical exercises which she says is like self-administered EMDR. Again, this confirms Norcross, Bike, Evans and Schatz's (2008) finding that not all psychological therapists seek their own personal therapy with some having other means of working through issues.

All participants in the current study are female. It is possible that this has implication for their self-care strategies. Norcross, Bike, Evans & Schatz (2008) found gender and theoretical orientation of therapist inform their inclination to access personal therapy. According to them, more female than male therapists access personal therapy and more psychodynamic and humanistic oriented therapists access personal therapy than cognitive-behavioural therapists. Many of the participants in this study have psychodynamic and humanistic theoretical underpinnings to their practice.

The role of supervisors is one thread that links all the themes in this study. For example, the study found that supervisors' influence is pivotal to how therapists work with dissociation. Participants find supervision to be a key

self-care strategy. This supports previous studies on the role of supervision in professional development. For example, Guest and Beutler (1988) found that the nature of supervisory experience in the early years of career still impact even after many years of experience and that supervisors influence the approach their supervisees utilise in their interventions. The current study finds that beyond supervisors' orientation, participants are also highly agentic and seek out supervisors who are able to meet their professional needs. This is perhaps because they are all well experienced psychological therapists who have grown to know their professional needs.

4.5.2. Implications for Clinical Practice, Policy, limitations of study and recommendations for further Research

4.5.2.1. Implications for practice

A significant implication of the findings of the current study is the need for pre-qualification training curriculum of counselling psychologists and other psychological therapists, across the board, to offer at least an introductory module on dissociation and other related complex client presentations like trauma and suicidality. If psychological therapists are to work effectively with clients presenting with complex and unusual presentations like dissociation, then they need to be prepared.

As the current study suggests, the extent to which psychological therapists incorporate assessment of dissociation to their intervention is subject to the influences of supervision and training. Shapiro (2001) opines that EMDR practitioners need to screen for the possible presence of dissociative features at the onset of intervention. This guideline, perhaps need to be extended to all psychological therapists. Working with knowledge of dissociative features has the potential of enabling positive outcomes and limit unnecessary extended period of therapy.

Many of the participants in this study identified ways that have worked for them in working with dissociation. This ranges from incorporating cultural perspectives, developing models of intervention, and working with the dissociative aspects of other mental health presentations. If participants in this study can be representative of psychological therapists, there is indeed a lot of evidence that can be generated from what works in practice. This has potential of informing the development of knowledge and skills in working with dissociative features. The implication of this is the need to harness what has been found to work in practice with a view to developing more robust practice and evidence based interventions.

Participants talked about taking a critical perspective to application of theories and models and devising their own models of they have found to work with their clients. Perhaps with more training on how to measure

what works, models can be learnt from practice that can be shared with wider populations.

In the current study, participants talked about having an integrative approach to their work with dissociation. Counselling psychologists, along with other integrative psychological therapists perhaps have a role to play in promoting the integrative approach to working with dissociation, one that honours and takes on a critical appreciation of different approaches.

The current study's finding that therapists' view on dissociation is often informed by their work environments, supervisors and perhaps have an important contribution to make.

4.5.2.2. Implications for Policy

The findings of this study have potential implications for health policy. The study in line with previous studies found that there are no official guidelines for working with dissociation. All participants in this study have identified dissociation in their clients. It would be useful if the experience of psychological therapists and other professionals who have working knowledge of dissociation is harnessed to give guideline on what works with dissociation.

If dissociation is identified early, not only would it benefit the client and therapist efficacy, it would also be cost effective as early intervention would mean that clients do not have to stay in mental health services longer than necessary.

The current study suggests that effective intervention goes beyond primary public health initiatives provided by frontline specialist services. Several models of dissociation have supported the notion that dissociation can be the result of attachment difficulties and early childhood trauma. Beyond intervention aimed at ameliorating the effect of these, preventative measures aimed at protecting children and other vulnerable young people from experiencing undue adverse experiences need to be initiated. Cutts (2003) found that counselling psychologists in the UK are increasingly becoming aware of social justice issues. Counselling psychologists and other psychological therapists can contribute to social policy based on their clinical experience and extend their contribution to the mental health of the population beyond therapy.

No one professional discipline and theoretical perspective can offer all the knowledge skills and values needed to work with people experiencing dissociation. There is need for information and knowledge on identifying dissociation. This would ideally be across multi-agencies and disciplines. A multi-agency agenda to working effectively with dissociation would ensure that different perspectives are consolidated. The benefits of multi-agency approach to working have been well articulated in some professional disciplines, for example social work and nursing. This approach to working with not only dissociation but any other mental health presentation would ensure that psychological therapists do not work in

silos. There is of course the issue of confidentiality which limits the ability of psychological therapists to share information with other agencies. However, when information is about abuse and maltreatment, psychological therapists have a duty to share information. Information sharing and collaboration across multi-agencies does not have to be only about therapy issues. It can be about contributing to health needs across local, national and international levels.

4.5.2.3. Methodological Strengths and Limitations of Study

The current study adds not only to the exploration of the knowledge-base of psychological therapists on dissociative features in client populations, it makes a significant contribution to exploring exactly what influences their adherence to particular ways of working with dissociation.

Another important strength of this study is that it gives voice to psychological therapists so that participants were able to articulate their individual lived experiences of working with dissociation and how these are informed by the context of the time and place in which they train and work. This is an important strength in the use of IPA as a methodology of choice. Participants represent psychological therapists who are at the forefront of working with clients in clinical populations and it is important to give a voice to their own conceptualisation of dissociation and the challenges of working with it. Larkin, Watts and Clifton (2006) posit that

IPA is useful in offering both the subjective experience of participants and an interpretative narrative of this.

Although this study revealed important insight into how psychological therapists develop their working knowledge of dissociation, in keeping with the spirit of IPA studies, participants were drawn from a homogenous group who are all female psychological therapists. It is possible that male therapists would offer a different insight.

Secondly, whilst using IPA has been useful in enabling interpretation of the lived subjective experience of the participants, interpretation alone has its limitations as it has meant that the primary researcher has not needed to verify the meaning of the data from the participants. Without epoche and confirming interpretation, which could have been possible in Husserlian phenomenology, the study has been limited to the primary researcher's interpretation of participants' data.

Whilst the study gives some insight into understanding of how psychological therapists develop there working knowledge of dissociation. The findings are specific to participants in this study. IPA does not seek to generalise knowledge. This is just a starting point which provides some indication of areas for further studies. It is possible that the findings of this study can be transferred to inform further studies, possibly using other research methodologies. Examples of areas that would benefit from

further study are transpersonal approaches and working with dissociation in disadvantaged populations like learning disabilities, gender differences in dissociative presentations.

4.5.2.4. Recommendations for further research

The current study has highlighted salient issues that merit further research. These include:

1. The role of diversity in the development of working knowledge of dissociation. Psychological intervention with dissociation would benefit from understanding more about how culture, gender and other structural agencies that exist in society has impacted on dissociative features in specific client populations.

2. The role of counselling psychologists and other applied psychologists, necessarily go beyond offering psychological therapy. What this study has shown is the need for more scientist-practitioner informed intervention. Having more therapists contribute to research, especially on what works in their practise would help to synthesise and perhaps guide official guidelines to working with dissociation.

4.6. Conclusion

In conclusion, the current study adds not only to the exploration of the knowledge-base of psychological therapists on dissociative features in client populations, it makes a significant contribution to exploring exactly what influences their adherence to particular ways of working with dissociation. The study found that the pre-qualification insight to working with dissociation, worksettings, supervisory experience, scaffolding by more experienced colleagues play significant impact on how psychological therapist develop their working knowledge of dissociation. Participants use their agencies to develop and access appropriate training to enable them further develop their knowledge and skills. Many of the participants take a critical approach to the application of theories and models, incorporating what they have found to work in their practice.

Participants talked about the challenges of working with multi-disciplinary and multi-agency colleagues who sometimes do not appreciate the role of dissociation in client presentation. This they found can be demoralising to them as psychological therapists. The extent to which participants found they could continue working with dissociation, is informed by their access to continuing professional development, support from peers and worksettings, and their self-care strategies which include sometimes making the decision to work with limited number of dissociative clients, engaging in activities that are not work related and accessing therapy when needed.

The study has implications for practice, training and mental health policy. There is need for more understanding of dissociation across professional disciplines and multi-agencies, more especially in relations to client populations like children and people with learning disabilities who the study found have been placed at disadvantage as a result of how dissociation presents itself with them. Counselling Psychologists along with other psychological therapists are at a vital position to contribute to these.

4.7. References

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Chapter 5 - Critical Appraisal of the Research Process

Thorns and Roses: A Critical Appraisal of my journey as a Doctoral Researcher

5.1. Introduction

This critical review offers an appraisal of my journey as a doctoral researcher. I have titled the review as thorns and roses as the term adequately reflects my experience on this journey. It has been exciting. It has been excruciating. It has been motivating and aspects of the findings have been crushing. I will offer a chronological reflection on journey. I will weave in insights on the thorny and rosy parts of the journey as I reflect. Whilst the learning process was often thorny, once I got into it, I appreciated the roses. The more I learnt, the more the roses appear.

5.2. Choosing a research topic

Prior to commencing on the Counselling Psychology doctorate, I had worked as a therapeutic social worker with specialist training in cognitive-behavioural therapy. Through my work experience I had come in contact with seasoned psychotherapists and had been encouraged to train in eye Movement desensitisation & reprocessing (EMDR). I undertook this training before starting on the course. It was through training in EMDR, discussion with other EMDR practitioners and attending EMDR supervision groups that I began to hear the discourse on dissociation. I wanted to know more about the presentation and in a discussion with a colleague, the idea was born that if I were to do a research study, it would

be on dissociation. I felt compelled to learn more about this presentation as it keeps cropping up in my professional circles. Whilst I know about it, the knowledge I had was basic and I did not have the skills to work with it. Furthermore, I was curious as to why it was only in EMDR and adjunct therapy models that have sprung from it, that I was hearing about dissociation. I wondered why I had not heard of it in my social work or CBT circles. I reasoned that if indeed dissociation is a legitimate clinical presentation, I would need to learn more about it and by extension contribute to knowledge about it.

5.4. Choosing a Methodology

The process of choosing a methodology was also a challenging one. I had wanted to use a constructivist grounded theory approach (CGT). However, the more I got into the study, the more I found that there is little in the literature to articulate the voices of psychological therapists. I gravitated towards Interpretative phenomenological Analysis (IPA). My reasoning was that as this was a nouveau study, theory construction was not the most important aspect but actually hearing the subjective lived experience of individual therapists. Later studies may focus on other aspects of research.

On my conversion course, I had learnt about phenomenology. What I did not realise was that phenomenological research is not homogenous. There are different types. I found it interesting reading the different views

on what constitutes phenomenological research from the transcendental to the hermeneutic; from the existential to the embodied. I read on critiques of IPA. I especially found the discourse between Giorgi and Smith engaging. I still made the decision to use IPA as my methodology of choice but had more informed understanding of its strengths and limitations. Having had the depth of understanding of research methodologies, I made the decision to write a chapter on this critical perspective which I intend to publish. The path to learning again was filled with thorns but I emerged from it with roses.

5.5. Writing the Literature review

I reflect that at the beginning of the process of writing the literature review, I had not appreciated how vast the topic of dissociation is. As I knew very little about the topic, I reasoned that it was appropriate to scope the literature. I found that there are many types of literature review. In discussion with my supervisors, I made the decision to offer a systematic narrative review. Thus whilst the review presented critique of the literature, it navigated a wide scope of the literature. This was in order to offer a comprehensive understanding of the field to both myself and the reader. I felt that I could not offer a narrow scope by researching on for example, dissociation in adolescents or dissociation in women as I needed to have a sound grasp of what dissociation is and the different views on it.

The research findings have already enthused me to continue studying in the field of dissociation. I have particularly been enthused by the cultural nuances and how it presents itself in different ways in diverse cultures and periods.

I found it interesting that whilst there is a large body of literature on dissociation, many taking alternate viewpoints, there were not specific studies on the journey psychological therapists and other clinicians had taken to arrive at their particular knowledge. It is this search for the epistemological stance of therapists that became the focus of the empirical study.

5.6. Empirical study

Finding participants for the empirical studies was tasking. On reflection, it is possible that asking professionals to define their stance on an issue of professional knowledge might be perceived as being a form of examination. I had carried out a couple of pilot studies and learnt first, that I needed to tone down my own need to impress about my knowledge of dissociation. I had little knowledge but I was articulating this in a manner that made a participant feel uncomfortable as she did not know about the concepts that I was bringing up.. fifteen minutes into the interview, she informed me that she had to attend to a call and consequently, never made herself available again.

Another thing I learnt through the pilot was not to rely on telephone or skype for interviews. The first few interviews I conducted were over the phone and skype. When it came to transcribing, I found that I was unable to make sense of some of the interviews as the volume was either low or the network was buffering. I resolved to travel for subsequent interviews and recorded with two equipment. This way, I ensured that interview data were of good quality.

With each of the participants, I felt I was accessing free training. They each brought so much richness and depth to the discussion on dissociation and enabled me to make better sense of the wider literature.
I also reflect on the pool of participants. I had made contact with several professional bodies, including professionals who work with clinical presentations that are similar to dissociation. For example, borderline personality disorder, I was anxious that my search for participants was not yielding fruit. It was only when I decided to use the professional networking site, LinkedIn, that I began to get responses. Another source of participants was from course mates who were aware of psychological therapists who work with dissociation.

I am aware that not all therapists consider dissociation to be a legitimate clinical presentation. It is therefore possible that those therapists, who do not relate to the concept of dissociation, did not respond to the request for participants.

In writing up the findings, I found that I had a struggle between using the term “clinical as opposed to “client” population. As a trainee counselling psychologist, I have imbibed the humanistic philosophical underpinning of seeing people and not their clinical diagnoses. However, as the term “clinical is widely used in mental health settings, I have used the two terms interchangeably.

5.7. Dissociating from dissociation

Gemignani (2013) opined that it is important for researchers to reflect on the emotions that come up for them as they go through the processes of research.. In undertaking the study on dissociation, I have found myself dissociating from dissociation. I have found myself going back to childhood and reflecting on some traumatic experiences and how I , like many of the participants in the study stress, can dissociate form unpleasant experiences.

As a trainee counselling psychologist, I had increasingly appreciated the value of having my own personal therapy. I engaged in personal therapy at a critical stage in the process of completing the process. I found that whilst I remained motivated to continue with the empirical study, I had stalled and was not doing much work towards completing it. Learning about dissociation, studies had found that working with self-states was a crucial aspect of intervention. I became more aware of my self-states.

The part of me that wants to be consistent on writing up the study, the parts of me that just wanted to be a mother, the parts of me that wants to read and engage in other personal development activities – all worthy except that they were not helping me to concentrate on the studies. Whilst friends and family were full of advice on the need to focus on the study, I was aware that there were deep intrapsychic issues at play.

Through personal therapy, I became aware of a deep need emanating from childhood which makes me not want to challenge others and be passive- aggressive. I will offer an insight here. I was coming from a session of personal therapy where I had been discussing what I experienced as impacting on my ability to focus on my study. I blamed it on the conflict between the time I needed to spend on writing my thesis and the time I need to spend on my mother role. During the session, it began to emerge that I did not find it safe or easy to articulate my needs to others. Rather, I tended to forgo my needs to meet the needs of others. The session ended and I needed to use the toilet. I thought “I am not afraid to ask to use the toilet but the therapist might not be comfortable with people going into her house to use the toilet. I will wait until I get on the train” On my way to the train station, I found it difficult to hold the water in and had to go right by the station. In that instant, I thought “See, this is another example of you not asking for help”. I gained insight into my reluctance to ask for supervisory support or help from family to take on

some of my roles. It was a watershed moment and I began to make better use of supervision and support from family.

5.7. Growth as a Person, Researcher and Practitioner

Undertaking this study has stretched my worldview and on reflection, I am aware that my starting point in the hermeneutic circle is not where I am now. On each step of the process of conducting this study, I have found that there is no linear understanding of any aspect of the study. Dissociation has historically been contentious and I found that contemporary debates have their roots in distant antecedents which span hundreds of years.

The study of dissociation has brought up a lot of reflections for me. In the review of the literature, I found that dissociation used to be called hysteria which derives from the Greek word for the uterus. As a woman, I felt aggrieved at the debasement of women who were often abused in patriarchal societies. To discover that the treatment prescribed to cure women of hysteria was the manipulation of their reproductive system, confounded me. I linked this to a debased saying which some men in my culture say about women who they find difficult to deal with:

"E fun ni nkan to n wa., kara re a bale"

This translated into English means, give her what she wants so that she will calm down. I still hear it said among the general population, those women who are strong-willed and difficult to control needing a man to satisfy them sexually. Whilst I have always challenged this view, knowing more about dissociation, stirred up a crusading spirit in me. This was a thorny moment in my research.

I began to see women who present with emotional and behaviour difficulties differently. I began to wonder about what traumatic experiences they might have had. This reflection was not only about women. It was about all people of all genders, young and old, able-bodied and those with physical and learning disabilities. My reasoning is that every human being is susceptible to trauma and abuse. However the structural inequalities in societies make some people more vulnerable to abuse, maltreatment and other traumatic experiences. If they exhibit dissociation, they are then likely to be even more abused through structural systems that do not place premium on the function of their dissociation.

I began to see expression of dissociation in the media, amongst my clients, in myself. One of my participants had talked about seeing it everywhere once you know about it. The questions that exercised me is "What function is dissociation serving?"

Studying dissociation has spurred me on to taking a public health perspective to my work as a counselling psychologist. This is an area I would like to develop. I am of the opinion that it is not enough to treat dissociation and other clinical presentations. Preventive measures are needed to reduce the prevalence.

Through the research participants and colleagues in the world of applied psychology and psychotherapy, I am becoming more aware of approaches that integrate the different systems in the human physiology to enable individuals to feel more fully integrated in themselves. Many of these approaches, including EMDR and some of its offshoots, do not yet have evidence base for dissociation. What they have are anecdotal evidences emanating from what have been found to work in practise. Some of these include Bilateral Affective Reprocessing of Thoughts, comprehensive resource model, developmental needs meeting strategies, lifespan integration and brainspotting amongst others utilise integration of cognition and affect and gut. In the words of one of the participants of this study, no one approach can meet the needs of all clients.

5.8. Conclusion

I will conclude that I have found the journey through conducting the research study as one that has enable d me to grow as a soon to be qualified counselling psychologist. It has entrenched my view that a pluralistic and integrative approach to the role of a counselling

psychologist is crucial. As a counselling psychologist with a background in social work, I aim to utilise my knowledge of multi-disciplinary and multi-agency work to contribute to knowledge of how attachment history and complex traumatic experiences contribute to how people develop their personalities. The field of dissociation is one in which I have taken a tiny step and hope to continue researching for years to come.

5.9. References

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Appendices

APPENDIX 1

Research Proposal Approval

Date: 15th April 2014

Oluwemimo Agboaye
65, Fullbrook Road,
Walsall,
WS5 4PB

Dear Oluwemimo

Re: Dissociative Features in Clinical Populations: An exploration of therapists' knowledge base and therapeutic perspectives, using Grounded theory.

Submitted to the Faculty of Education, Health and Wellbeing Ethics Sub-Committee Board (Health Professions, Psychology & Social Care)

The Faculty Ethics Sub-Committee (Health Professions, Psychology & Social Care) met on **14th April 2014.** Your project was considered and reviewed at this meeting.
On review your research proposal was passed and given approval **(Code 2 – Pass (Researcher/Supervisor to Monitor).** You are free to begin your study contingent on addressing any minor amendments detailed below.

Supervisors must ensure the minor amendments have been completed prior to commencement of data collection.

We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM

Chair – School Ethics Committee
D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE
Chair – School Ethics Committee

APPENDIX 2: ETHICAL PROPOSAL FORM

Please complete and submit the three components, which together make up the ethical approval form document – (i) The Researcher Checklists; (ii) Investigator, Supervisor & Research project details; and (iii) your Protocol.

1. Researcher Check Lists (Part A)[1]

Once you have answered all the questions below and the relevant documents have been included please send this to your supervisor for submission.

Procedural Aspects Prompts This is the first researcher checklist and aims to help ensure you have addressed all the salient procedural aspects of the ethical approval process. It should be submitted completed as part of your ethics application form. If you answer No to any of the items below, your submission is likely to be returned to you without being reviewed.			
1. Have you completed and included all three parts of the submission document? i. Researcher Checklists ii. Researcher, Supervisor & Research Project details iii. Your Research Protocol with Appendices	Yes ☒	No ☐	N/A ☐
2. Does your project protocol include an electronic signature from your supervisor? (For supervised projects only)	Yes ☒	No ☐	N/A ☐
3. Is your protocol 1,500 words (+ or – 10%)?	Yes ☒	No ☐	N/A ☐
4. Have you included ALL necessary Appendices documents?	Yes ☒	No ☐	N/A ☐
i. Original letter of access and/or approval letter or some other form of approval in principle from organisation	Yes ☐	No ☐	N/A ☒
ii. Letter/Email Inviting participants to take part Note: University rather than personal contact details should be used in documentation	Yes ☒	No ☐	N/A ☐
iii. Consent form	Yes ☒	No ☐	N/A ☐
Iv Consent form involving access to medical records	Yes ☐	No ☐	N/A ☒
v. Participant information sheet	Yes ☒	No ☐	N/A ☐
vi. Debrief sheet	Yes ☒	No ☐	N/A ☐
vii. Data Collection Materials & Procedures (e.g.	Yes ☒	No ☐	N/A ☐

[1] To complete the checklist boxes either double click and select checked or right click select properties and then select checked. If you select the wrong box and cancel, rather than selecting checked or unchecked, the box will disappear; undo to make the box reappear.

questionnaires, interview schedules, training/intervention details etc.)			

Ethical Approval Form

Ethical Consideration Prompts This is the second researcher checklist and aims to help ensure you have addressed all the salient ethical issues. It also aims to help you to decide if your study is a category A or category B project. It should be submitted completed as part of your ethics application form				
1. Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?		Yes ☒	No ☐	N/A ☐
2. Will you tell participants that their participation is voluntary?		Yes ☒	No ☐	N/A ☐
3. Will you obtain written consent for participation?		Yes ☒	No ☐	N/A ☐
4. Will you avoid coercion?		Yes ☒	No ☐	N/A ☐
5. If the study involves observational data collection, will you ask participants for their consent to being observed?		Yes ☐	No ☐	N/A ☒
6. Will you tell participants that they may withdraw from the research at any time without giving a reason and with no repercussions?		Yes ☒	No ☐	N/A ☐
7. With questionnaires, will you give participants the option of omitting questions they do not want to answer?		Yes ☐	No ☐	N/A ☒
8. Will you tell participants who will have access to their data?		Yes ☒	No ☐	N/A ☐
9. Will you tell participants that their data will be treated with full confidentiality (detailing data protection and storage procedures) and that, if published, data will be anonymised? If you cannot guarantee full confidentiality (e.g. due to potential safeguarding issues). Select No but explain this fully in the protocol.		Yes ☒	No ☐	N/A ☐
10. Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study).		Yes ☒	No ☐	N/A ☐
11. Will you provide participants with the option of receiving a lay summary of the main findings?		Yes ☒	No ☐	N/A ☐
12. Will your study involve deliberately misleading participants in any way? (Category B)		Yes ☐	No ☒	N/A ☐
13. Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details in the ethical issues section of in Part B and/or in your Protocol (Part C) and state how this will be handled (e.g. who the participant can contact for help). (Category B)		Yes ☐	No ☒	N/A ☐
14. Does your study involve work with animals? (Category B)		Yes ☐	No ☒	N/A ☐
15. Do participants fall into any of the following special groups? (Category B) Note that you may also need to obtain satisfactory CRB clearance (or equivalent for overseas students).	Schoolchildren (under 18 years of age)	Yes ☐	No ☒	N/A ☐
	People with learning or communication difficulties	Yes ☐	No ☒	N/A ☐
	Patients/Clients (including people with diagnosed psychological or health conditions)	Yes ☐	No ☒	N/A ☐
	People in custody or offenders	Yes ☐	No ☒	N/A ☐
	Other vulnerable groups (e.g. crime victims, homeless people, substance misusers etc.)	Yes ☐	No ☒	N/A ☐
16. Does your study involve collecting sensitive secondary data (e.g. records regarding cause of death, abuse, neglect etc.) (Category B)		Yes ☐	No ☒	N/A ☐

17. Is this study going to an external ethical review committee (e.g. IRAS, REC, NOMS etc.), if so please give details below.	Yes ☐	No ☒	N/A ☐
External Approval will be sought from: N/A			

You must bring to the attention of the Ethics Committee any additional issues with ethical implications not covered by the above checklist.

Ethical Approval Form

2. Investigator, Supervisor & Research Project details (Part B)

Investigator's Details (Must be completed)

Title: Mrs
Forename: Oluwemimo
Surname: Agboaye
Position: Doctoral Student, Counselling Psychology
Qualifications/Expertise of the investigator relevant to the submission: MA, MSc, DipPsych
Email address: o.agboaye@wlv.ac.uk
Address: 65, Fullbrook Road, Walsall,
Postcode: WS5 4PB
Telephone number: 07976945015
Alternative contact number: 01922620776
Supervisor's Name & Contact details: Dr Niall Galbraaith and Dr Abigail Taiwo
Are you as the Investigator or is your Supervisor a member of the ethics committee?: No

Title of the Research:
Please indicate the type of submission (See Section 3 for Guidance):

- ☐ Category 0 Undergraduate project self-certification
- ☐ Category 0 Other
- ☒ Category A
- ☐ Category B

Please indicate whether the study is:

- ☐ Staff Research (Externally funded) - Dept./Institute:
- ☐ Staff Research (University funded) - Dept./Institute:
- ☒ Postgraduate student Project
  Programme of study:
- ☐ Undergraduate student project - Programme of study:
  Programme of study:

How many words is your protocol[2]: 1,375

Key Words: Dissociation, Complex trauma, Depersonalisation, Derealisation

Please LIST below the major ethical issues you have discussed in the attached research protocol.

2

Your protocol should ideally be 1500 words (+ or – 10%), we acknowledge that in some instances (e.g. for large scale, multi-component studies) this may not provide sufficient space to adequately describe your study. In these cases we will accept longer protocols up to a limit of 3000 words.

- Ethical approval will be sought from the ethics committee.
- No data collection would be commenced until after ethical approval has been obtained.
- The researcher will maintain participant anonymity
- The data from the study will be stored for 2 years and then destroyed confidentially.
- All participants would be volunteers. There would be no deception. Written Informed consent would be obtained from participants.
- All study participants will be briefed about procedures and informed of any potential risks.

RESEARCH PROTOCOL

1.1 Title of the proposed research.

Dissociative Features in Clinical Populations: An exploration of therapists' knowledge base and therapeutic perspectives, using Grounded theory

1.2 Theoretical & Literature Based Background to the Study

Recent research studies indicate that dissociative symptoms are as common as anxiety and depression, and that, individuals with dissociative disorders, particularly Dissociative Identity Disorder, are often misdiagnosed for many years, delaying effective treatment (Liotti, 2006; Sternberg, 2008). Brand, McNary, Myrick, Classen, Lanius, Loewenstein, Pain, & Putnam (2012) note that patients with Dissociative Identity Disorder often seek treatment for a variety of other problems including depression, mood swings, difficulty concentrating, memory lapses, alcohol or drug abuse, temper outbursts, hearing voices, psychotic symptoms, physical ailments including headaches, unexplained pains and memory problems. Thus, children, adolescents and adults are left undiagnosed for a considerable length of time after presenting to mental health services (ISSTD, 2011). Studies have shown that in spite of the prevalence rate of dissociation in clinical population, individuals presenting for intervention are not routinely assessed for the dissociation. Similarly, clinicians are not necessarily trained in understanding, assessing and treating the phenomenon. This has implication for therapy effectiveness and outcome Brand, Myrick, Loewenstein, Classen, Lanius, McNary, Pain & Putnam, (2012).

1.3 Rationale & Research Question/Aims/Hypotheses

Studies have shown that there is a relationship and mediating factors between dissociation and other presenting mental health diagnosis like depression and anxiety disorders. The diagnosis of dissociation is subject to clinician's awareness and ability to recognise it. It is therefore possible that the prevalence rate is higher than is known. The proposed study is important as it has the potential to contribute to how mental health settings assess and treat the condition. Exploring the understanding of clinicians who have some level of understanding of dissociation will help to raise awareness of training needs and gaps. This will have implication for initial and post qualification training in mental health.

The aim of the proposed study is to conduct an inquiry on the experience and understanding of theoretical perspective to dissociation amongst therapists and how they assess and treat clients with dissociative features.

Specifically, the research questions are:

- What theoretical framework underpins therapists' understanding of Dissociative Features?
- How do therapists assess and treat dissociation?
- How do therapists derive evidence that their approach works?

1.4 Research Design/Approach.

The proposed study will utilise a qualitative exploration of therapists' conceptualisations and operationalization of dissociation within therapy. Specifically, the qualitative methodology to be used will be grounded theory (Glasser & Strauss 1967; Charmaz 2006). Grounded theory is chosen as the research methodology, as it provides a framework for an in-depth examination of participant conceptualisations as well as their practice. It would enable the exploration of the contextual factors that inform therapists' understanding and treatment of dissociative features in their clients.

1.5 Recruitment, Sampling & Study Participants.

The proposed participants would be drawn from membership of the British Psychological Society (BPS) and other accredited counselling and psychotherapy bodies. The selection criteria would be for the participants to have substantial experience (at least five years) of working with clients who exhibit dissociative symptoms. This would enable an exploration of how they have evolved in their understanding and treatment of dissociation. Whilst the interview of 6 participants is unlikely to enable saturation to be reached, it would provide enough information to inform further studies.

1.6 Materials/Data Collection Method(s)

Semi-structured interviews would be employed to gather the data (see appendix 1 for schedule and topic guide). It covers open ended questions relevant to the research aim. The interviews will be audio-recorded.

1.7 Data Collction Procedure

Semi-structured interviews would be carried out with up to 6 participants. Participants would be briefed about the purpose of the study. They would be given information letter and would be given informed consent forms to read and sign. A form to elicit demographic information would also be administered to participants. The questions would include:

- Gender
- Years of experience
- Client population
- Membership of accredited professional bodies
- Theoretical perspective

It is proposed that the interview would last for between one and one and half hours. The interviews would take place at locations convenient to the participants. All interviews would be recorded on audiotape, and transcribed. Consistent with Glaser's (1992) constant comparative method, research data would be open coded, selectively coded, and then theoretically coded so that initial codes were collapsed models and compared against existing literature for completeness.

It is envisaged that there will be minimal risk to the safety of the participants and the researcher, as participants are to be drawn from professional pool who are themselves guided by professional ethical frameworks.

1.8 Data Analysis

Through the grounded theory analysis of the interviews, core conceptual categories and sub-categories would be identified. The interviews would be coded following Glasser's (1992) three-stage process of analysis. In stage one, open coding, item-by-item codes would be identified to capture inherent concepts. In stage two, axial coding, the various concepts from the first stage would be grouped into themes or conceptual categories. In stage three, selective coding, superordinate categories that subsumed the existing concepts and themes, would be sought. Once the conceptions, themes and superordinate categories from both the questionnaires and the interviews were identified, they would be compared and organised into one coding set.

1.9 Ethical considerations.

The proposed research will adhere to the BPS ethical guidelines for research. Ethical approval will be sought from the ethics committee. No data collection would be commenced until after ethical approval has been obtained.

The researcher will maintain participant anonymity. Identifying information and individual responses will not be shared with anyone who is not involved in the study. Data will be protected by keeping questionnaires, transcripts and interview recordings in a secure facility, accessible only to the researcher and her supervisors. The data from the study will be stored for 2 years and then destroyed confidentially by shredding the paper documents, permanently deleting documents on the computer and breaking up and shredding audio tapes.

The participant pool would be drawn from professionals who routinely work with clinical population with dissociative features. Whilst their names would be known to the researcher, their anonymity would be ensured as these would not be in the research report. Professional discipline, therapeutic models, length of experience, population worked with and demographic information, including age, gender, religion and ethnicity would be obtained to aid analysis. It is important to obtain these demographic information in order to explore influences on perspectives.

All participants will be volunteers. There will be no deception. Participants will not be coerced, threatened or bribed into participation. Written Informed consent will be obtained from participants. All study participants will be briefed about procedures and informed of any potential risks. It is envisaged that potential risks would be minimal.

Participants will be thoroughly debriefed at the end of each interview. They will be given a general idea of what the researcher is investigating and why. Their part in the research will be explained. They will be asked if they have any questions and those questions will be answered honestly and as fully as possible.

1.10 Potential problems.

The researcher has considered the challenges of recruiting participants who have substantial experience of working with dissociation. Whilst the pool of participants is restricted, drawing participants from diverse psychotherapy organisations means that there is potential for appropriate participants to be identified.

Asking for participants who have a certain level of experience of working with clients with dissociative features might lead to possibility of participants perceiving that they are being assessed and/or judged. In order to mediate against this, the researcher will be explicit about the aim of the study, which is to understand how therapists develop knowledge and skills in working with dissociation.

Whilst pseudonyms would be used in the research report, there remains the risk that participants might be identified through use of quotes. To mitigate against this, the researcher would not include any quotes that contain private information.

1.11 Pilot study.

A pilot study consisting of two interviews will be carried out in order to test the workability of the proposed study. Findings from the pilot study would have the potential of flagging any issues and improve the quality and efficiency of the study. Any deficiencies in the design, procedure and structure of interview questions of the study can be identified and redressed before time and resources are expended on the main study. If the pilot study does not lead to significant modification of procedures and questions, the data would be incorporated into the main study.

1.12 References.

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APPENDIX 3: FORMAT OF SEMI-STRUCTURED/INDEPTH INTERVIEW

Demographic Information:

- Gender

  Years of experience
- Client population
- Membership of accredited professional bodies
- Theoretical perspective

THE RESEARCHER WILL LET THE INTERVIEWEE TELL THEIR STORY AND USE THE QUESTIONS BELOW AS PROBES/REMINDERS

(

Part 1) <u>UNDERSTANDING OF DISSOCIATION</u>

What does 'dissociation' mean to you?

Probe: Let the interviewee tell you what they understand dissociation to be.

Give your own definition

Have a discussion about the definition.

(Part 2) **<u>GIVE PARTICIPANT A DEFINITION OF DISSOCIATION</u>**

Please explain how you develop an understanding of the concept?

- ***How and where did you discover the concept?***

  Probe: Ask them to relate their journey into the world of dissociation

Prompt: Who are the influences on their journey?

Was the concept taught during your core professional training?

Probe: To what extent?

Prompt: Describe your first experience of working with dissociation

(Part 3) ASSESSMENT

Please describe the primary reason for referral for the clients you assess as having dissociative features.

Probe: Ask them to relate experiences

Supervision, multidisciplinary input, training?

Prompt: How do you assess for dissociation?

What psychometric measures, if any, do you use in your assessment?

(Part 4) INTERVENTION

Please describe your treatment approach?

Probe: How has your treatment modalities evolved?

What criteria do you use to assess the outcome of treatment approach?

(Part 5) **PROFESSIONAL DEVELOPMENT**

Where has support for you development come from?

What are the needs that you feel your professional body/training organisations can help you with?

Probe: Training?

Raising awareness with public?

Raising awareness with multi-agency professionals?

Resources?

Peer support?

Other?

Prompt: How well do you think that professional bodies/training organisations are meeting these needs? (after each of above sections)

(Part 6) FINALLY:

Thank you for your time. Do you have any questions that you would like to ask of me?

Part 7 DEBRIEF

APPENDIX 4: LETTER TO PARTICIPANTS

Dear Colleague

I am writing to invite you to participate in a research project, which I am conducting as part of a Doctoral study in Counselling Psychology at the University of Wolverhampton. The proposed study is a qualitative study of Clinicians who have substantial experience of working with dissociative features in clinical population. I enclose an information sheet, which explains the title and aims of the project and what taking part will involve.

If you are willing to be interviewed, the interview would take no longer than an hour and half. Anything you say would be totally confidential and any notes made

as a result of the interview would be destroyed afterwards. The interview would take place at a location and time that is convenient to you.

A report will be written of the findings and all names will be replaced with aliases, so that you cannot be identified. If you feel that you would like to be interviewed please indicate by contacting me through my email address o.agboaye@wlv.ac.uk.

Yours sincerely,

Wemi Agboaye

Doctoral Student in Counselling Psychology

APPENDIX 5: CONSENT FORM

CONSENT FORM

Title of Project: Dissociative Features in Clinical populations: An Exploration, using Grounded Theory, of Therapists' knowledge base and therapeutic perspectives

Name of Researcher: Oluwemimo (Wemi) Agboaye

Please initial boxes

1. I confirm that I have read and understand the information sheet, version 1, dated 05 March, 2014 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am freeto withdraw at any time, without giving any reason. ☐

3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication ☐

4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐

5. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐

6. I agree to take part in the above study. ☐

……..	……..	…….
Name	Signature	Date

……	……	…….
Researcher	Signature	Date

APPENDIX 6: DETAIILED PARTICIPANT INFORMATION/DEBRIED SHEET

Study title

Dissociative Features in Clinical populations: An Exploration of Therapists' knowledge base and therapeutic perspectives, using Grounded Theory.

Wemi Agboaye
Doctoral Student in Counselling Psychology, University of Wolverhampton

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please let me know, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
Recent research studies are showing that the prevalence of dissociative features in individuals presenting to mental health services is higher than was previously thought. For example clinical presentations like depression or anxiety disorder may be associated with dissociation.

The researcher is intrigued to know the perspectives of experienced colleagues who have working knowledge of dissociation on how they came to know about the phenomenon and what approach(es) they take to intervention.

The findings of the study would be useful for policy, practice and education of clinicians across professional backgrounds and would inform future studies in this area. For example, it would provide indications of what form(s) of training clinicians need, at what stage of career development clinicians would benefit from learning about dissociation and how outcomes are evaluated.

Why have I been chosen?
You have been chosen for this study because of your working knowledge and substantial experience of dissociation. The researcher is interviewing clinicians like you, to understand your experiences and perspectives on working with dissociation. Your experience will provide useful information that could inform the training of mental health professionals and organisational policy with regard to assessment and intervention of individuals presenting to clinical services.

Do I have to take part?
The decision on taking part would be yours to make. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time before the analysis of data.

What will happen if I decide to take part?

If you decide to participate in this study, the researcher will contact you to arrange a suitable time and location for the interview. It is envisaged that the interview time will be for approximately one hour. The interview will be audio-recorded and transcribed.

In the interview, you will be asked about your background training, subsequent trainings and years of experience. The researcher will be interested in how you came to develop your working knowledge of dissociation and what theoretical perspectives you take to working with the phenomenon. The interview data will be analysed, using the qualitative research methodology, Grounded Theory.

What are the potential benefits and risks of taking part?
Your participation will offer a unique opportunity for insight on clinicians' approaches to working with dissociation. This research study has the potential of making an original contribution to the research literature on understanding how clinicians work with dissociation, thus informing practice and education for mental health professionals.

There are no risks to you in taking part outside of those you would experience in everyday life. However, by taking part, you may remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected. There are no right or wrong approaches as the study is interested in a diversity of perspectives.

Will my taking part in the study be kept confidential?
Yes. All the information about your participation in this study will be kept confidential and personal details will be anonymised. The transcription of the interview you participate in will be stored on a password protected computer in a locked office. Only the researcher and her supervisors will have access to the information. You will not be identifiable in any publication or report as all identifying information will be removed.

What will happen at the end of the research study?
A doctoral thesis would be produced and the summary of the thesis can be disseminated at your request. It is envisaged that a journal article will be written from the thesis and submitted to an appropriate journal for publication.

What if I have a problem or concern?
If you have a concern about any aspect of this study, you may speak to the researcher or the research supervisors who would do their best to answer your questions. **Contact details of the supervisory team are as follows:**

Dr Niall Galbraith – First Supervisor
n.galbraith@wlv.ac.uk

Dr Abigail Taiwo – Second supervisor
a.taiwo@wlv.ac.uk

Who has reviewed the study?
The research ethics committee in the faulty of Education, Health & Wellbeing of the University of Wolverhampton has reviewed this study. If you will like more information about this, please contact the research supervisors.

Contact for further information
If you have any questions or require further information about this research, please contact the researcher:

Wemi Agboaye
Doctoral Student in Counselling Psychology
o.agboaye@wlv.ac.uk

Thank you for your participation in this study. Your involvement is very much appreciated and will make significant contribution to understanding the importance of having a working knowledge of dissociation and how clinicians may develop knowledge, skills and values in this area. It will also offer potential developments in research on prevalence of dissociation in clinical practice.

APPENDIX 7

Emergent themes and Exploratory Comments - Participant 8 - Hannah

Emergent Themes	Original Transcript	Line Number	Exploratory comments
Supervisory influence on evolution. Talk about power relations and striving to be agentic. To forge own path determinedly	…and that's where I kind of…I continued being determinedly psychoanalytic but I gradually changed under the influence of my supervisor.	196 – 198	There appears to be a pull between striving to be agentic and owning one's own path to professional development and the power relations between self and one's supervisor
Defining Dissociation Dissociation as process	Dissociation as a process… rather than a set of symptoms. I would see that there is a process, a psychological process… which mediates a lot of symptoms and things which are called 'dissociation'… But also a lot of other mental health problems in which dissociation isn't recognised	284 – 295	Dissociation as process not symptom. Participant sees dissociation as a process that mediates other mental health problems
A Cognitive-Behavioural definition of Dissociation	So the process would be that the information processing systems switches from association, which it normally is information processing through, to dissociation, so its neurological inhibition of the normal associative processes.	300 – 304	Participant offers a cognitive explanation to the dissociative process.
Situated knowledge Barriers to identifying dissociation Structural inequalities	I saw it in learning disability, but I didn't recognise it… Because people weren't able to verbalise their internal world so easily. And then when I moved into the mental health work, again I got people entrenched and treatment-resistant and a lot of them of course turned out to have massive abuse histories.	356 – 364	Knowledge of dissociation depends on time and place. Dissociation can be easier to identify in some clinical populations than others for, example, clients with history of abuse. In LD population, communication difficulties can present barrier.
First encounter with dissociation "Strange presentations"	I began to get a number of clients with dissociative identity disorder … who were extremely strange. People who had come dressed one way one day and they'd come dressed completely differently the other day and they'd speak differently and their accents might be different…	366 – 374	Perhaps, more studies would be useful in helping to work with dissociation in LD population. Non-verbal

			approaches to assessing dissociation would be useful.

APPENDIX 8

Stream of Emergent themes from four participants

Anne	Ceyone	Folake	Gail
Levels of Experience/ Expertise Novice to expert Importance of supervision/consultation Self care Commitment and dedication to clinical population Ongoing learning Learning curves Collaboration with client – Do with or do to Influences on development On-Training Evolving competence Passion Eclectic/Integrative Client-Centred Confidence Critical view to approaches Owning her own approach Case example First client with dissociation Power relations –age of therapist and client Duration of therapy Importance of	Years experience Substantial = 30 years Specialisation Theoretical orientation Eclectic DBT/CBT Psychodynamic informed Use of the term “Client not Patient” Change to the term “patient” “End product” Psychodynamic origin of dissociation Outcome Power relations EMDR Systemic Wide range of training Eclectic Uses what works with each client. Not purist End product Medical vs psychological model Appreciation of psychological	40 years post qualification experience Journey into Psychotherapy On the job learning before formal training as a psychotherapist Integrative approach Approach informed by interest in black psychology and humanistic approaches Finds home in psychoanalytic tradition Critique of Freud on function of psychology Owning own approach Evolved on approach to psychotherapy African-centred psychodynamic Agency vs structure Positioning self Critique of Freud Psychology study of spirit or behaviour? Critique of Freud Critique of Freud	Post qualifying experience Pre-qualifying work experience Attitude to professional organisation membership Reason for attitude Theoretical orientation Eclectic Impact of training on practice Experience of diverse supervision EMDR Generic approach to theoretical orientations Influence of work setting and clinical population on model of practice Psychoecucation to clients Defining dissociation Influences on developing working knowledge of dissociation Training Case experience

supervision and training Use of pronoun “we” implies collaboration Eclectic approach – EMDR/Ego therapy Learning curve Impact of supervision Theoretical orientation Learning from reading Influences on learning Learning from reading Influences on learning Theory of structural dissociation Theory to practise Learning curve Importance of training – having parts in charge Learning curve Working with parts Use of language First conscious experience of working with dissociation Understanding dissociation Theoretical orientation EMDR Observing forms of dissociation Importance of observing changes in feeling and memories Attitude to assessment and diagnostic measures	aspects End product Psychological aspects of patients experienced as minefield Theory into practice Need to learn psychological aspects Impact of cultural background Situated knowledge Mystery Effect of migration on learning Neurotics vs Psychotics Power relations Work environment Private vs public body Defining Dissociation Recognising relationship between trauma and dissociation Psychological and physical forms of dissociation Diagnostic criteria Dissociation as process Dissociation in	Qualified as a psychiatric nurse Relational approach to psychotherapy Learning from what works in practice Devising own approach from what works Cultural competence Working with silence Using unconventional approach – Breaking silence Sensing into people’s feelings Practise-based evidence Approach to Therapy - psychospiritual Multi-agency work Large group Diverse groups Collaborative approach: Use of the pronoun “We” Nostalgia for the past Creative approaches to therapy Physical activities Influence of work setting on therapist approach Creativity Changing jobs	and quest for knowledge Reading books Power relations Discussing dissociation with client Sharing case in training Reading Diagnosing client Identifying dissociative features in client Attitude of multidisciplinary colleagues Client seen as manipulative Wandering through the woods The role of training in understanding dissociation The search for training Metaphor: Casting around Role of popular culture Pull Desire to for positive outcome Role of supervisor Mention of dissociation in pre-qualifying training Strangeness of client

Novice to expert Assessing Dissociation Novice to expert Different symptoms of dissociation Levels of dissociation How dissociation presents in different clients Types of dissociation Attitude to assessment and diagnostic measures Novice to expert Using measures for insurance pupose Cross-cultural understanding of dissociation Attitude of multidisciplinary colleagues Working with dissociative clients Fixing Relationship between trauma, attachment and dissociation Dissociation not always about sexual abuse Case example Infant-mother transaction and dissociation Relationship between attachment and dissociation Anxiety and dissociation Assessing dissociation	clinical population Role of emotional dysregulation Self-harm and dissociation Pre-qualification training Psychodynamic approach to treating dissociation Case example Learning through reading From novice to expert Dissociation as mystery From novice to expert Behavioural approach to dissociation Frequency of dissociation in determining extent of trauma Learning through reading Learning through practice On-going learning Dissociation in physical presentations Onset of dissociation Impact on learning Learning from	Experience as therapist before training Multidisciplinary team Use of pronoun “we” Team working Influence of wok setting Creative and innovative approaches Inter-culture psychotherapy Training Role of supervision Feminism use of the pronoun “we” Role of supervision Role of mentoring Innovative service Pioneer and innovative service Exploring what works with black women Service aims and objectives Situational knowledge Situated knowledge Radical Use of pronoun “we” Using what works Adapting approaches Not rigid to any approach Confidence to work with any clinical presentation	presentation Attitude to diagnoses/Beyond diagnoses Dissociation and other clinical presentations Ongoing training Impact of technology Web-based training Financial implications Time Critique of training Owning one’s view Dissociation and other clinical presentations Critical approach to training Distinction between dissociation and psychosis Maintaining curiosity Puzzlement Impact of work setting on approach to work Length of intervention Struggle between personal ethos and organisational constraints Struggle with knowing what to do Use of supervision Influence of supervisor on development

Common humanity Dissociation and attachment Learning from multimedia Attachment and dissociation Relationship between attachment, abuse and dissociation Normalising dissociation Dissociation in adolescents Attitude to theories and models Approach to inner child work Eclecticism Stabilising technique Identifying resource spots Primary model EMDR/Ego State work Lifelong learning Continuous learning Joining professional organisation Self care Peer supervision, group supervision and socialising Self-care Cultural identity Unwinding from hard cases Self-care: Being able to say no to new cases Self care	reading Readiness to work with dissociaiton Working with dissociation Power relations Dealing with it Fixing the broken parts Understanding the why of dissociation Fro, understanding dissociation to correcting it Psychoeducatio n Power relations – informed choices Openness Uniqueness of each client Power relations – client choice Informed choice Use of professional discipline Psychoeducatio n Case example Professional as client Maintaining curiosity about client's presentation Looking beyond presenting issues Power relations Working with powerful families Dissociating from spousal	Situated knowledge Neurotics and psychotics Metaphor: Castle Metaphor of ladder and castle Neurosis to psychosis The function of clinical presentation Defining Dissociation Vagueness Situated knowledge Situated knowledge Influence of work setting Defining dissociation Defining Dissociation Tentative Defining Dissociation Fear of being judged Defining dissociation Venturing into offering a definition Defining Dissociation "Flitting to somewhere different Defining dissociation Psychodynamic Fear of potential psychic pain	View on supervisor Supervisory influence Person-centred Impact of training on recognising dissociation "Spotting it all over the place" Primary reason for referral Tension between supply and demand Managing cases Contribution to multidisciplinary team Organisational constraints Multidisciplinary team Supervision Access to supervision Financial implications Situated knowledge Training opportunity Impact of work setting The power of service users Individual vs agency Service responsiveness Theoretical orientation Ego state work/Working with parts

Boundaries – Having limited numbers of dissociative cases Self-care – Variety of clinical presentations. Limited number of dissociative cases Self-care – Vacations Age and self-care Self-care: Physical exercise Non-work related activities Self-care – Close relationships Non-work related activites Thearter, novels, friends who are not therapists Watching comedies Writing Consulting Case example – Consulting Self-care – Using different parts of self Speaking engagements, writing, consulting Self-care – Getting help with vicarious trauma Metaphor for cases – horrible, terrible Self-administered EMDR Peer administered EMDR Maintaining boundaries – Limiting number of cases Agency vs structure privilege of working in	abuse Function of dissociation Moving beyond clinical roles - Distancing clients from abuser Attachment Internal working model – father to husband Long-term nature of working with dissociation – 10 years Collaboration Multidiscip[linary working Looking beyond referred individual Dissociation in parents Assessing readiness to leave dissociation Function of dissociation Case example Collaboration – multidisciplinary team working Use of the pronoun “we” Male client Dissociative amnesia Therapy model – Abreacting Looking beyond presenting issues Role of trauma in dissociation Power relations – clients defining	Case example Client with long history of mental health intervention Drawing from case example: Normalising dissociation Use of supervision Drawing from case example: Looking beyond presenting issues. Presenting issues might be forms of dissociation Drawing from case example: The importance of relational approach Use of dreams Case example: Meaning making Relationship between early childhood maltreatment and dissociation Working with challenging clinical population Dissociation as defense mechanism Use of supervision Power relations Slow is faster Ethical dilemma: Choice Dissociation as defense mechanism Learning about dissociation through clinical work	Theoretical orientation Judith Herman (Trauma model) Learning through reading Therapy outcome Tentative nature of intervention In-house training Individual vs agency Learning from clients Phenomenology Learning from lived experience Financial implication Impact of funding Impact of trainer Impact of training Attitude to diagnosis Role in diagnosing Does not diagnose Divergence Psycho-education Collaboration with client Accepting diagnosis of Dissociation: Momentous The function of dissociation Importance of collaborative approach Accepting diagnosis of dissociation: Catastrophic Client-led Impact of ongoing family relationships on working with dissociation

private practice Therapist emotion about work Agency gives satisfaction Agency and job satisfaction Keeping sane Longevity of working with clinical population Knowledge of Dissociation in pre-qualification training Learning post qualifying Training junkie Evolution of attitude to dissociation in pre-qualification training CBT and dissociation Evolution of understanding of dissociation: Understanding dissociative presentations Evolution of understanding of dissociation: Learning from books Situated knowledge Pre-qualifying training Learning in pre-qualifying training Learning in pre-qualifying training: Learning from books Joining professional organisations Attending conferences.	their own experience of trauma Dissociation as repression Maintaining open-mind Understanding the stance of the client Function of manipulative behaviour Common humanity Attitude to self-care Need for support Self-analysis as a method of self care Self-care Physical exercises Self-reflection Understanding stress threshold Self-care Physical activities and endorphins Self-EMDR Self-administered EMDR Normalising dissociaiton	Influence of supervision Pride in practice Influence of supervisor Validation Training Influence of supervisor Supervisory guidance Training opportunities Power relations Importance of supervisory relationships Supervisor's validation. Professional development Therapist's individual therapy Situational knowledge Training experience Drawing from theoretical orientations Attachment theory Infant-mother relationship Transactional model Therapist's use of self Common humanity Counter-transference Therapist's use of self Infant agency: Drew mother out of depression Positive side of	Impact of contact with abusive family Case example: Client's emotion: terrified Therapist's uncertainty Therapist's emotions Impact of ongoing contact with abusive families on intervention Attitude to using Diagnostic tools Influence of supervisor Attitude to diagnostic tools Somatic measures Attitude to assessment measures: Influence of supervisor Therapy model Confidence level Supervision Attitude to training Medical vs trauma model Attitude to training Value informed training Dissociation in pre-qualification training Situational knowledge Importance of learning about dissociation early

		parentification Values intuition above training Motivation to get trained: Credibility Financial implications of training Class and the psychological therapy profession Establishing pedigree in professional background Psychoanalytic orientation Theoretical orientation Working with the unconscious, use of hypnotherapy, Mind Defining dissociation Normalising dissociation Pseudo-pregnancy Dissociation as a cognitive process	Self care Conflicting response to experience of working with dissociation Adjectives: difficult, interesting, wonderful, engaging Attitude to working with dissociation Knowing what works Working with parts Engaging

APPENDIX 9

Cluster of Emergent Themes under subordinate themes – Gail and Hannah

First Cluster – Gail:

Subsuming and clustering of emergent themes under subordinate themes

1. **Pre-qualification experience**
   Situated knowledge - Mention of dissociation in pre-qualifying training
   Importance of learning about dissociation early

2. **Expectation to be expert**
   Struggle with knowing what to do

3. **Continuing development**
   Owning one's view
   Influence of supervisor on development
   Impact of training on recognising dissociation - "Spotting it all over the place"
   Learning through reading
   Desire to for positive outcome

4. **Influence of worksetting**
   Influence of work setting and clinical population on model of practice
   Attitude of multidisciplinary colleagues - Client seen as manipulative
   Impact of work setting on approach to work
   Length of intervention
   Struggle between personal ethos and organisational constraints
   Tension between supply and demand
   Managing cases
   Contribution to multidisciplinary team
   Organisational constraints

   Multidisciplinary team

5. **Definitions and theoretical perspectives**

   Theoretical orientation – Eclectic
   EMDR
   Generic approach to theoretical orientations
   Person-centred
   Theoretical orientation
   Ego state work/Working with parts

   Theoretical orientation Judith Herman (Trauma model)
   Medical vs trauma model

6. **Identifying dissociation**

   Wandering through the woods
   Diagnosing client - Identifying dissociative features in client
   Role of popular culture
   Role of supervisor
   Attitude to diagnoses/Beyond diagnoses
   Dissociation and other clinical presentations

7. **Client Presentation**
   Impact of unusual client presentation - Case experience and quest for knowledge
   Strangeness of client presentation
   Distinction between dissociation and psychosis

8. **Learning from colleagues**
   Experience of diverse supervision

9. **Accessing training**
   Impact of training on practice
   Reading books
   The search for training - Metaphor: Casting around
   Ongoing training
   Impact of technology
   Web-based training
   Critical approach to training
   Financial implications
   Time
   Critique of training
   Situated knowledge - Training opportunity
   Use of supervision
   Attitude to training - Value informed training
   Supervisory influence
   Access to supervision - Financial implications
   In-house training - Individual vs agency
   Learning from clients
   Phenomenology - Learning from lived experience

10. **Common humanity**
    Attitude to diagnosis
    Role in diagnosing
    Does not diagnose

11. **Role of client and therapist in therapy**
    Psychoecucation to clients
    Power relations
    Discussing dissociation with client - Sharing case in training
    The power of service users
    Individual vs agency - Service responsiveness
    Therapy outcome Tentative nature of intervention
    Role of Therapist - Maintaining curiosity, puzzlement
    Psycho-education
    Collaboration with client
    Accepting diagnosis of Dissociation: Momentous
    The function of dissociation
    Importance of collaborative approach
    Accepting diagnosis of dissociation: Catastrophic
    Client-led
    Impact of ongoing family relationships on working with dissociation
    Impact of contact with abusive family
    Case example: Client's emotion: terrified

Therapist's uncertainty
Therapist's emotions
Attitude to working with dissociation: fun
Clients giving token gifts
Working with parts
Ethical consideration of receiving gifts from child parts

12. Self-care

Importance of supervision
Out of work activities
Boundaries/Limits
Does not read about dissociation outside of work
Vicarious traumatisation
Boundaries/Limits"
Importance of keeping "sane"
Conflicting response to experience of working with dissociation
Adjectives: difficult, interesting, wonderful, engaging

Second cluster: Hannah:

Subsuming and clustering of emergent themes under subordinate themes

1. Pre-qualification experience

Training trajectory I initial training in Behavioural therapy
Rebelled
Client presentation

2. Expectation to be expert

Agency of Therapist
Reading about dissociation
Feelings: Challenged, confused
Importance of Knowledge of Dissociation – Preassure to know - I'm the lead here. The buck stops here.

3. Continuing development

Forging own path – seeking a CBT understanding of dissociation
Supervisory influence on evolution. Talk about power relations and striving to be agentic.
To forge own path, determinedly
Cultural influences – move abroad
Agency of therapist vs structure of training/work setting - Situated knowledge
Influences on development
Situated Knowledge – random opportunities to learn about dissociation

4. Influence of worksetting

Knowledge of dissociation and working models situated in specific time and place
Situated knowledge - Barriers to identifying dissociation - Structural inequalities

5. Definitions and theoretical perspectives

Three levels of dissociation - Is this any different from Van der kolk's theory of structural dissociation?
Agency of therapist – learning cognitive element of CBT
Continual evolution of knowledge
Explaining dissociation of personality – CBT perspective
Alternative views from CBT tradition Cognitive restructuring vs cognitive diffusion
Cognitive-Behavioural techniques to working with dissociation
Attitude to integration of approaches
Not into EMDR but able to draw from what appears to work in it to understand CBT approach
Power relations – CBT vs EMDR. Description of hemispheric understanding of brain functioning as "nonsense"
Metaphor used to describe compartmentalisation: Trauma cabinet, monsters
Illustrating compartmentalisation
Working with parts
Influence on understanding – Jeff Young.
Influence of theoretical orientation to understanding dissociation
Situated knowledge psychoanalytic vs CBT
Types of dissociation – detachment and compartmentalisation
CBT model of Dissociation
Dissociation as a useful concept

Dissociation as continuum
Dissociation as psychological process
Integration of EMDR
Evidence-based practice
Therapist preference - CBT vs Psychoanalytic
More research studies needed

6. Identifying dissociation

Knowledge of dissociation and working models situated in specific time and place
Defining Dissociation- Dissociation as process
A Cognitive-Behavioural definition of Dissociation
Limitation of Wessex dissociation Scale
Psychological measures for assessing dissociation
DES vs Wessex Dissociation Scale
Saves effort
Economics

Effective intervention
Positive outcome

7. Client Presentation

First encounter with dissociation
"Strange presentations"
Reaction to novel client presentation - Feeling of helplessness. Fear?
First encounter with dissociation
When dissociation does not work, other clinical presentations may surface
Unbelievable stories
Differentiating between cases
Dissociation and other clinical presentations

Learning from colleagues

Influence of supervision

Accessing training
Reading as a form of professional development
Influences on development
Agency of therapist – seeking to fill gaps in knowledge
Making sense and meaning out of readings

Working with multi-agency colleagues
Credibility with macro systems-
court system/Psychiatry
Integrity of therapists
Accusation that therapists make up dissociation
Struggle with powerful sceptics British psychiatric Association
Accept that dissociation can be faked
Abuse of office
Multiagency work
Scepticism about sceptics
False memory syndrome society – critique
Challenges of multi-agency work

Common humanity
Just like clients with complex clinical presentations are sometimes accused of making it up
Normalising dissociation
Institutionalised oppression
Dissociation always present in PTSD
Susceptibility
Power relations
Institutionalised nature of abuse
Institutional abuse - Religion

Role of client and therapist in therapy
Stabilising techniques
Power relations – agency of client on behavioural experiments
Use of client network (spouse)
Methods of working with dissociative clients
Psycho-education
Experiential exercises
Impact of ongoing contact with abusive families on intervention

Self-care
Attends conferences
Delivers training
Self care
No longer takes on Dissociation cases
Now in Private practice
Trains and supervises
The exhausting nature of working with dissociation
Impact of working with dissociative clients on therapists
Vicarious traumatisation
Intellectual approach to self-care
Use of metaphor - Stuck self in mask – Dissociating from dissociation?
Clients stories impacting on therapists' worldview
Emotion laden work

Appendix 10: Cross Case Analysis – identifying recurrent themes

Super-ordinate Theme 1: Novice to expert

Subordinate themes	Anne	Beth	Ceyone	Diane	Emma	Folake	Gail	Hannah
Pre-qualification experience	NO	YES	YES	NO*	NO	YES*	NO	NO
Unusual Client presentation	YES	YES	YES	YES	YES	YES	YES	YES
Expectation to be expert	YES	YES	YES	YES	NO	YES	YES	YES
Continuing development	YES	YES	YES	YES	YES	YES	YES	YES

- Pre-qualification knowledge of dissociation not necessarily important

Superordinate Theme 2: Search for Knowledge

Subordinate themes	Anne	Beth	Ceyone	Diane	Emma	Folake	Gail	Hannah
Learning from colleagues	YES	YES	YES	YES	YES	YES	YES	YES
Influence of supervision	YES	YES	YES	YES	YES	YES	YES	YES
Accessing training	YES	YES	YES	YES*	YES	YES*	YES	YES

- Financial constraints to accessing training

Superordinate Theme 3: Working with Dissociation

Subordinate themes	Anne	Beth	Ceyone	Diane	Emma	Folake	Gail	Hannah
Theoretical perspectives	YES	YES	YES	YES	YES	YES	YES	YES
Identifying Dissociation	YES	YES	YES	YES	NO	YES	YES	YES
Influence of worksetting	YES	YES	YES	YES	YES	YES	YES	YES
Challenges of multi-agency work	YES	NO	YES	YES	NO	NO	YES	YES

Superordinate Theme 4: Use of self

Subordinate themes	Anne	Beth	Ceyone	Diane	Emma	Folake	Gail	Hannah
Common humanity	YES	YES	YES	YES	YES	YES	YES	YES
Normalising dissociation	YES	YES	YES	YES	YES	YES	YES	YES

Role of client/therapist	YES	YES	YES	YES	YES	YES	YES	YES
Self-care	YES	YES	YES	YES	YES	YES	YES	YES

Appendix 11: Cross-analysis master table with illustration of themes

Superordinate theme	Subordinate theme	Participant, Quote and Line no
Novice to Expert	Pre-qualification Experience	"Nobody said a word about trauma…nobody said a word about suicide and nobody said a word about dissociation." (Anne, Lines 884 - 885). "And at the time (I don't know how it is now) we were allowed to request specific areas that we might like to have somebody come in and talk about." (Beth, lines 536 – 539). "it was definitely taught as part of our psychodynamic/psychiatric training…" (Ceyone, lines 249 – 251).
	Client presentation	"the first time….it was a lady who… came in and sat down and …she screamed and she sat sort of back in her chair and her eyes rolled back and she rocked and she curled up in sort of a foetal position on the chair and rocked and just cried and screamed...quite an alarming presentation." (Beth, lines 256-266). "So I'm hearing this story in an assessment, and part of me is thinking, 'Well, he doesn't really mean that,' and then the other part's saying, 'Do I need to inform a GP or the doctor or the police? And where's my supervisor? And where's my boss?' (Diane, lines 582 – 586). "there's a person that stands out that used to speak French sometimes in sessions and become very childlike. So she had, I guess… and thinking about, it, there's a lot about her life which seemed strange." (Gail, lines 327 – 331). "…She was having absolutely none of it. But all of her behaviour, all of her psychotic breakdowns, happened around the time her father…there was an incident with her father, when her father finally died, the incident with the house, it was always around the father. But she would not allow it to penetrate her conscious… She would not allow it. So it had to be pushed out. Dissociated. Everywhere else but where the issue was 'cause she could not allow herself to actually face that. Could not allow herself. And it was that that I thought, 'Okay, I've got it. I've got this dissociation thing, this." (Folake, lines 539 – 549). And I was thinking, 'What the hell is going on?'

		sort of thing. It was that extreme presentation really, that I had no idea how to deal with it. I had no idea how to think about it and yet I had these people in my office. And I had no one to give them to. This was about twelve years after qualifying." (Hannah, lines 376 – 390).
	Expectation to be expert	"…another therapist was having trouble with her, sent her to me" (Anne 87 – 88). "I'd been in practice maybe three years or four years… and then I got this client. And I may have seen other people but I didn't know…But now I know! I can…I can spot dissociation now." (Anne, Lines 192 – 197). "What stirred up…'Oh, right, okay. I need to read up on this so at least I've got something to say.' Because I think it was underpinned by fear. I'm thinking, 'My goodness, here am I fully fledged, and actually I don't know much about dissociation or dissociative disorder." (Diane, lines 309 – 314). "You don't always have to know everything and you don't have to get it right but you can be in that, like, safe in uncertainty… of being curious…" Emma, lines 401 – 405).
	Continuing Development	"everything that I learnt has been out of school, and I have been a workshop junkie ever since. A training junkie. I keep learning. " (Anne, 716 – 718) "…and I thought, 'Well this is really interesting. This is…you know, I'm hearing some echoes with what people are telling me in assessments and what you're telling saying. I think I need to learn a bit more about this.' (Emma, lines 252 – 256). "There was something pulling me. It just seemed like, 'Oh gosh, that just sounds like the sort of thing that might really help me with this client.' (Gail, lines 298 – 300).
Search for Knowledge	Learning from colleagues	"When I was working in the psychotherapy service there was one very, very experienced psychotherapist who was a lovely person, and she specialised in dissociation, and I think it was having my conversations with her that introduced me to dissociation. So it was, yeah, my contact with her that enabled me to be much more aware of dissociation." (Diane, lines 394 – 401).

		"I've been fortunate in having a professional lead who's very interested in dissociation and who has supported that in terms of also being aware that her experience has been that more and more people are being referred with these kinds of difficulties…and needing to kind of up-skill." (Emma, lines 852 – 858).
	Influence of supervision	Supervision's really key to not be carrying that stuff, is to…to discuss it and get support and… and think about how things affect you … and what impact hearing those things has, is really helpful. (Emma, lines 1000 – 1005). "we were being supervised and monitored by (Name withheld), from the (Name withheld) and (Name withheld) and other eminent feminist psychotherapists, who had set up the Centre…" (Folake, lines 304 – 308). "that's where I kind of…I continued being determinedly psychoanalytic but I gradually changed under the influence of my supervisor." (Hannah, lines 196 – 198).
	Accessing training	"People may come in and you're not aware they're about to dissociate or that's there...So it is sort of learning on your feet to some extent … think the moment that happens – and it's happened to a few of us – we go and seek the training because… you need that knowledge. " (Beth, lines 221 – 225). "One of the best papers on dissociation, I forget the author, is actually written way back in 1960s, and I think it was titled The Trauma of Abuse." (Ceyone, lines 331 – 335). "…we went on specific training about dissociation, which was very helpful. But until that point I didn't really know what it was, or how it manifested itself, or even maybe how to manage it." (Diane, lines 226 – 230). "one of the things that I've found really useful is that there's like a skills book for…I think it's called Trauma-Related Dissociation and that very much is for service users as well as professionals and talks…and helps you through that process in terms of getting some stability". (Emma, lines 872 – 873). There's lots of kind of different trauma models. I think I'm thinking in terms of Judith Herman's approach. So she's got a book about trauma and recovery, which is very focussed on

		dissociation as well and thinking about, um, how you integrate experiences." (Emma, Lines 73; 100 – 106). it's like a self-help book, really. But it gives you activities and kind of…um, ways of thinking about what's going on. So I find that really useful as a basis.(Emma, lines). "There were very, very few places and you did it privately and you were white and you were middle-class and you had money. Otherwise you weren't doing it because you couldn't afford it." (Folake, lines 689 – 693). "It was free training for lots of staff here. Trust paid for a couple of days…. people do understand more about dissociation now" (Gail, lines 693 – 694). "It was free training for lots of staff here. Trust paid for a couple of days…. people do understand more about dissociation now" (Gail, lines 693 – 694). "And I was reading a book edited by Paul Salkovskis and it's called Frontiers of Cognitive Therapy. 1996. And there's a chapter in there by, Tim Beck and it's called Personality and Psychopathology. It's basically a model of how the cognitive stuff that we know about information processing and responding connects with personality in the CBT world… then Jeff Young came along with his Schema." (Hannah, lines 436 – 434). "It was free training for lots of staff here. Trust paid for a couple of days…. people do understand more about dissociation now" (Gail, lines 693 – 694). But it's such a challenging end that it made me think about it and learn about it . And so then I started reading about DID, which got me even more confused." (Hannah, lines 409 - 412).
Working with dissociation	Theoretical perspectives	"if you work with dissociation, you're not just going to do CBT". (Anne, lines 580 – 591). "I take the parts I think work and leave the rest. What I say is I don't do any therapy right. I do what works for the client in front of me." (Anne, lines 415 – 417). "I'm probably more inclined to do either dialectical behaviour therapy or cognitive behaviour therapy…I do use a lot of psychodynamic psychiatric principles to understand my client, but I do not work in a psychodynamic way…for example, I'd be very

		aware of transference and counter-transference. I'd be very aware of mirroring, the relationship I had with a patient was that…I'd be very aware of all of those psycho-dynamic principles, including dissociation. I think dissociation comes from the psycho-dynamic field…Occasionally, I might use eye movement desensitisation and processing…I do use a lot of systemic principles when I'm assessing families and making my own assessment, and then trying to help them to move forward". (Ceyone, lines 54 – 79). "when I started to study dissociation, I liked the whole notion of the unconscious, I like the whole notion of hypnotherapy… and the power of the mind." (Folake, lines 726 – 728). "One of their child parts always brings me… which is odd, isn't it, because, I mean, you're taught not to accept gifts from people. But, it's just very difficult when you have child parts who don't understand that really and who haven't had a mother. You have to find some kind of way of bridging that gap somehow." (Gail, lines 954 – 960). "I basically also was educating myself in the cognitive element, because when I trained, it was behavioural training. Which is great because now we're a third wave of CBT." (Hannah,lines 421 – 424). "…looking at it from an attachment… approach… And bringing in sort of trauma models in relation to that. But attachment as the underpinning as to how people perhaps respond to trauma. So, you know, thinking about someone's attachment style and how they might cope differently with trauma, compared to somebody with a different attachment style." (Emma, Lines 73; 100 – 106). "Nobody knows how EMDR works but EMDR does work. There was an interesting presentation (CBT conference) by (Name withheld) and he'd studied EMDR and why it works, like left brain, right brain and all that stuff. Which is a load of nonsense. But what he did find was that this is more effective than tapping… And the reason he thinks that it's more effective is because you can show that it occupies working memory sufficiently to distract the brain from the dissociative response long enough for the information to be processed normally . Because I think working memory is

		important in distinguishing the threat because it's that very short information loop about what's going on in front of you, sort of thing. (Hannah, lines 997 – 1018). "EMDR's the best way to find a DID client. You start doing EMDR and they…soon you go, 'Oh.' You know? But I had to start asking questions first, now. And when I ask people about their history, I watch them like a hawk…and if they start talking about something bad that happened and they…I see a real switch, they might not be DID but there might be some dissociation or at least bad PTSD, which is dissociative state. You know, you run through the switch when you're getting the history, you ask them "if…about something that will bring up a feeling and if they have ample tolerance , if they can share the feeling and be with it…then they are able…they aren't going to be dissociative." (Anne, Lines 198 – 213).
	Identifying Dissociation	"Sometimes I think if dissociation doesn't present, it's not considered …so perhaps it was there in CAMHS but because we didn't overtly see it… …it didn't become part of what I did. Whereas in (Location withheld) there it was." (Beth, lines 495 – 506). "I think it's about taking a stance as a professional, where you're open to looking for it, to being ready for it, because if you're not ready for it, you will miss it. So I don't think that there is a particular way that a client would present to you. I think it's more about having the awareness as a professional, and looking for it, and then that will help you to deal with it better." (Ceyone, lines 363 – 370). "We are coming across it more often. I don't know what that's about, whether it's just that we know more about it and there is that idea that when you know about something you see it everywhere. Um, so maybe that for me is a bit of what is happening. Certainly I've noticed more and more people since I've done the training" (Emma, lines 963 – 970). I've never kind of held too much with diagnoses anyway." (Gail, line 353). "I'd been casting around for all sorts of things and I think probably I thought about multiple personality disorder but I didn't really know anything about that. I had come across a few people in the past with…who I thought, 'That sounds a bit like what they used to call multiple

		personality disorder.' And like many people, I suppose, at that stage, my understanding was very rare and I'd hardly ever met anyone like that. There's been a couple of films made. A couple of classic films about dissociation; dissociative personalities. So, I kind of thought, 'Well, this does sound a bit like that, but it probably isn't." (Gail, lines 254 – 267). "I think for me it's about a way of coping with traumatic experiences that, um, involves kind of a basis of attachment in terms of perhaps being avoidant of a particular stimuli, you know, in terms of a trauma. And dissociation being the ability to cut off from a particular event or a particular set of feelings." (Emma, lines 112 – 118). "Sometimes I think if dissociation doesn't present, it's not considered …so perhaps it was there in CAMHS but because we didn't overtly see it… …it didn't become part of what I did. Whereas in (Location withheld) there it was." (Beth, lines 495 – 506). "I think it's about taking a stance as a professional, where you're open to looking for it, to being ready for it, because if you're not ready for it, you will miss it. So I don't think that there is a particular way that a client would present to you. I think it's more about having the awareness as a professional, and looking for it, and then that will help you to deal with it better." (Ceyone, lines 363 – 370). "We are coming across it more often. I don't know what that's about, whether it's just that we know more about it and there is that idea that when you know about something you see it everywhere. Um, so maybe that for me is a bit of what is happening. Certainly I've noticed more and more people since I've done the training" (Emma, lines 963 – 970). "if you ask me if I could recognise dissociation straight away in somebody, I think my honest answer is no, I couldn't." (Diane, lines 170 - 173). "I still feel very new in my understanding of dissociation. Just coming back from the first couple of days. I suddenly just thought, 'Actually, I'm understanding what you're saying now. That makes sense in terms of what I've learnt from these couple of days,' and I opened up to ask more questions." (Emma, lines 266 –

		270).
	Influence of worksetting	"…And the biggest mistake I made with that client, which I have not made since, is my first consultant told me I must always be available for this client, okay? If she needed something, I was there. And so I had calls in the middle of the night, I had calls on the weekend, I…you know, all kinds of things . What I have since learnt is that you find in the adult parts in these client…and you make them available 24/7 to all the other parts, you know ." (Anne, Lines 126 – 134). "There were social workers, there were counsellors with a social work background, counsellors with a psychology background and counsellors with a nursing background. There were two of each..And we all got together and our brief was to work with women who would normally not be referred for counselling." (Folake, lines 290 – 297). "most manipulations have a functionality… to them. So what you're describing is just a description of the behaviour. What you're not doing right, accurately, would be understanding what that means to that person. It's only until you look for that, that you then realise that manipulation has a functionality. You know, who is not manipulative? Even a small child is manipulative. The tiniest of babies, what do they do? They manipulate their environment by pooing and crying. So everybody is manipulating within their ability and depending on their need." (Ceyone, lines 599 – 610). "There was often the implication, that this is a wilful thing; somehow to try and get care or to try and keep involved with people." (Gail,lines 228 – 231). "I've been in practice since then and it was a few years after that I got my first DID client. (Anne, Lines 83 – 84). "When I was working in the psychotherapy service there was one very, very experienced psychotherapist who was a lovely person, and she specialised in dissociation, and I think it was having my conversations with her that introduced me to dissociation." (Diane, lines 394 – 401). "I used to start with a long-term view…most people I work with. And I'm still struggling with that now, because you've got massive waiting

		lists. And work I want to do is spend time with people and give them as long as they need. But we can't do that. We're being increasingly told we can't do that. So you have to limit it somehow. I literally can't do it, because otherwise I would never get through these cases." (Gail, lines 441 – 450). "I saw it in learning disability, but I didn't recognise it… because people weren't able to verbalise their internal world so easily. And then when I moved into the mental health work, again I got people entrenched and treatment-resistant and a lot of them of course turned out to have massive abuse histories." (Hannah, lines).
	Working with multi-agency professionals	"How is it in the UK? Here there are many psychiatrists and, like, hospitals that do not believe in dissociation. They just think everybody's borderline and if they have more cognitive therapy they'll be okay" (Anne, Lines 316 – 320). "he was found homeless and wandering when we first picked him up, and they brought him on a police section." (Ceyone, Lines 540 – 541) I did what I could do, but sometimes I feel frustrated, because I'm only part of a chain of people who need to be acting together cohesively, and sometimes that doesn't happen . And we know about this politically with baby P, and Victoria Climbié… (Diane, lines 662 – 667). "we've cut off from dissociation and trauma because it's painful to think about. In a similar way to the way in which, you know, sort of sexual abuse has been ignored for a large proportion of time because it was painful to think about." (Emma, lines 974 – 982). I've never had any desire to feel special in that way. In fact, I'd rather not. It's like people often say people make up sexual abuse to feel special. Or they make up multiple personality disorder to feel special. I always say, 'Well it's a damned shame if you've got such a sad life that you have to make stuff like that up.' (Hannah, Lines 1863-1869).
Use of self	Common Humanity	"…personally how did I cope when my mom died last year?...it was only maybe three or four months after she passed away that I then felt all

		the sadness. So possibly for me I was going through some type of dissociation after mom died and I think this happens to lots of people." (Diane, lines 143; 159 - 163). I am one of my mother's favourite children. She brought me close to her … she was very depressed and there was something about me that kept her… …alive. And she said, 'You saved my life. You kept me alive. ' And I was incredibly engaging, and I brought her out of it, you know what I mean ? If you ever hear my mother talk about raising children, I am the only one she remembers and will give examples about. I was, 'Come on Mummy, come on Mummy, come on Mummy, come on Mummy!' Yeah? And it was like I dragged her out of the depression, and I think what I learnt in that process is how to intuit what was going on with people. From a very early age. That's why I'm a good psychotherapist. (Folake, Lines) "The experience of personal therapy, the experience of understanding what makes you tick and why you tick like you tick takes you to then be able to understand at a meaningful level what makes other people tick. Now they may be broken and twisted and whatever in different places, the way you were broken and twisted… you know what? We're all broken and twisted." (Folake, lines 1170 – 1177).
	Normalising dissociation	"All we need to do is find the ladder, then we can communicate with the people who are living in the castle…find out what it is that tipped them over from good old neurosis that we all have, into what is so unbearable about this experience that they actually would prefer to be in another reality" (Folake, lines 358 – 364).
	Role of client and Therapist in therapy	"some people are able to say, 'that doesn't fit for me,' or, 'I would find it very strange talking to that child.' Yeah. So in that way we'd reframe it a little bit and say, maybe talk to a child who may have been in that situation. It doesn't have to be you as the child." (Beth, lines 452 – 457). "It's very interesting. If you have something which is together but is broken, you don't put it right just like that. You have to first of all understand how it's together, despite being broken, then figure out how you're going to remedy it to fix the broken part and still keep the strength of the patient." (Ceyone, lines 375 – 379).

		"Just getting to know them and helping them to feel safe, if possible, and letting them guide me in what they wanted to talk about, really. Some people would have said that was very woolly. But I just think most people need to have their story heard…" (Gail, lines 477 – 484).
	Self care	"I take vacations." (Anne). "as a privileged, white person who's been in practice a long time, I can be in private practice and choose." (Anne, lines 748 - 750). "I exercise a lot. I've noticed that when I'm exercising, I'm repossessing constantly." (Ceyone, lines 631 -633). "I go to the theatre regularly, I read novels once in a while, I have good friends who don't do what I do for a living. We talk about other things and, you know, I follow television shows that aren't all about work, you know? And I like to watch science fiction. Dr Who, for instance. I like Dr Who, because he has problems I never will have to deal with, you know? Very different problems than I have. And I'm a movie fanatic. But not the violent ones. I have enough violence at work… (Anne) "I couldn't do it without great supervision…I have various supervisions…that I can take the issues to." (Gail, lines 961 – 964). "I'm very aware of my stress levels at any one time. I know when I've got to stop and kind of de-stress." (Ceyone, lines 636 – 637). "I usually have, um, out of maybe seventeen clients I might see in a week…there won't be more than three who are in a highly dissociative place because I'll be…they'll drive me crazy, you know? I need to take care of myself." (Anne, lines). "I find being physically active is very important physically in terms of the endorphins, but I find it very important for other things too. It's literally like an EMDR for me ..Because I am processing." (Ceyone, lines 649 – 653). "I had a lot, a lot of therapy. I was in therapy… because at that time everybody in my world was in therapy." (Folake, lines 610 – 612). "…well I do my spiritual work. So do yoga, qui gong, I meditate, I eat well. I love people. It's not an effort for me. I am what I am, I do what I

		do.” (Folake, lines 1116 – 1118).